THE CALIFORNIA HMO HELP CENTER Annual Report 2001

"JOHN Q. DOESN'T LIVE HERE ANYMORE"

READY TO RESOLVE YOUR
HMO PROBLEM

ON THE COVER:
Clockwise, starting at the top:

"The people at the HMO Help Center were on our side all the way through. Thanks to them, my son got the home health care he was entitled to." Nicole Breslin of San Jose

“If not for the HMO Help Center, it would have cost me hundreds of thousands of dollars to stay alive, money that I didn’t have.” Dr. Mario Baur of Los Angeles

"We were out of luck if the medical review board hadn't come through for us..." Shelley Cultrera of Stockton in *The San Francisco Chronicle*. Cultrera went through independent medical review to win access to a specialist for a rare kidney disease.

This report and more information about the HMO Help Center, the Department of Managed Health Care, the Business, Transportation and Housing Agency, our Patient Advocate, and your HMO rights and responsibilities are available at www.hmohelp.ca.gov or by calling 1-888-HMO-2219.

This report contains an aggregate summary of grievances against plans filed with the director by enrollees or subscribers as mandated by the Knox-Keene Act, Section 1397.5 and the annual audit of the independent medical review system mandated by the Knox-Keene Act, Section 1374.34(e).

In addition to providing the mandated complaint data, this report describes the accomplishments of the Department of Managed Health Care’s HMO Help Center during its first 18 months of operation. The Department of Managed Health Care was launched on July 1, 2000, to help Californians resolve problems with their HMOs as well as to ensure a better, more solvent and stable managed care health care system.

June 2002

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EXECUTIVE SUMMARY

When you're sick and need to see a doctor, you don't want to stand in line, sit on hold or fill out forms. You want to get the quality care to which you're entitled, without interference from an HMO. That's what California's HMO Help Center is all about: helping consumers who are having HMO problems resolve them quickly and effectively.

"[The Department's HMO Help Center]...has proven effective in resolving consumer questions and complaints." *The San Francisco Chronicle, 1/28/2001*

The Department of Managed Health Care opened the HMO Help Center on the very first day of the new Department: July 1, 2000. Operating 24 hours a day, 7 days a week and staffed by teams of patient rights experts, health care professionals and customer service representatives, the HMO Help Center receives and responds to nearly 500 consumer calls every day and in every and any language spoken by California's diverse population.

"[The Department] was our salvation. I think they probably added several years to my son's life. He is now healthy and can do everything he wants to do." *Danville resident Angie Birdwell in the California Journal, July 2002*

Our first full year, 2001, was extraordinary. First, we eliminated a significant backlog of unresolved consumer complaints left over from the previous regulator. At the launch of the HMO Help Center, we inherited a caseload that was nearly two-thirds more than a month old. By the beginning of 2001, we reduced that backlog to less than 5 percent.

"The [Department] asserts and we concur that the [HMO Help Center] has helped the [Department] identify systemic problems in the managed care industry and also resulted in positive outcomes for individual consumers." *Report from the Legislative Analyst Office of the California State Legislature, 12/05/2001*

More important, for the first time in our state's and indeed our nation's history, an organization solely dedicated to helping HMO patients and enforcing their rights, was providing a wide range of HMO patient advocacy services ensuring that, at the end of the day, doctors had the final word on HMO patient care.

"…Based on interviews with patient advocates, health care lobbyists and policymakers around the state, there is a broad consensus that the department is largely filling [its] pledge to create a consumer agency that is responsive to patients and effective in addressing their concerns. Observers said the agency has responded swiftly to cases that involved medical emergencies, has cut through HMO red tape to end delays in providing care and has quickly resolved misunderstandings between plans and patients." *The Los Angeles Times, 7/30/2001*

In 2001, the HMO Help Center provided assistance to 179,966 Californians via telephone assistance, complaint processing or independent medical review. All issues were resolved by our ground-breaking complaint management system:

> "[The Department is] much more consumer friendly…the whole attitude of the Department seems to be much more open and sensitive to consumers needs." *Earl Lui, Consumers Union, California Journal, 7/2000*

- Telephone Calls Received – 171,182

  Interactive Response - Almost 40% of all calls to the HMO Help Center are resolved by a digital interactive voice response system, which provides basic information such as the contact numbers for the major HMOs' internal customer service and complaint offices. In 2001, 63,631 calls were resolved through this system.

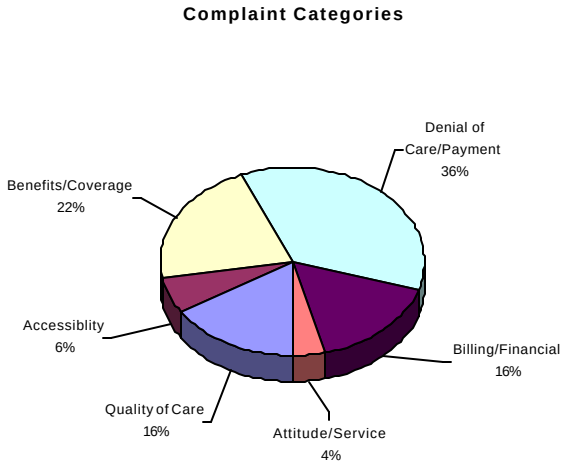
  Quick Resolutions - Another 905 calls were resolved on the spot or within days by our patient rights representatives. In some cases, our representatives bring a live representative from the HMO on line with the consumer in a three-way call to expedite the resolution and eliminate additional delays.

  Urgent Issues – There were 1,133 issues that we felt required an immediate resolution. These issues were handled by our clinical staff who deal directly with the HMO and the consumer.

  Other Issues – The remaining 105,513 calls were handled by the agents in the Call Center.

- Provider Line - In addition to the 171,182 calls from consumers, 3,321 calls were received on our physician/provider line. Of these calls to our physician/provider line, 90% percent involved questions about claims or a billing dispute. This dovetails with nearly $445,000 in fines against HMOs that weren't paying doctors on time, or at all, and millions in back payment and interest penalties, as well as the takeover of three state HMOs where a serious financial crisis was threatening patient care.

- Formal Complaints – The HMO Help Center resolved 4,740 actual complaints having the more complicated issues, requiring detailed information from consumers such as medical records. These are resolved within days or weeks.

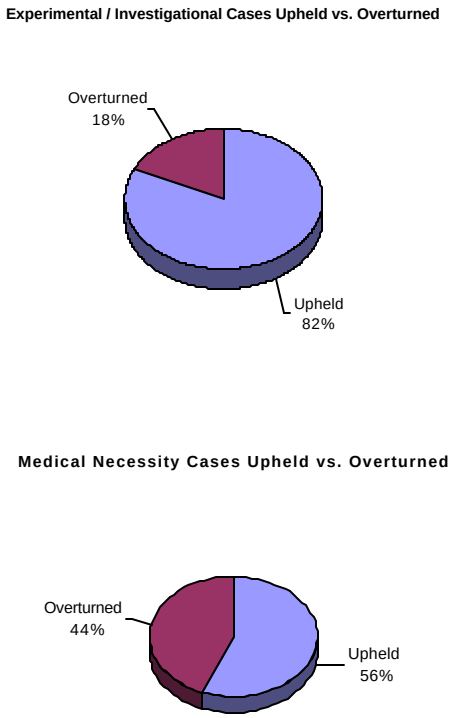


- Independent Medical Review – In 2001, 723 patients with some of the most difficult and subjective cases involving the medical necessity or proven effectiveness of certain treatments had those cases heard before a panel of independent physicians, outside their HMO, whose decision was binding on the HMO.

There can be no doubt that Independent Medical Review is the centerpiece of the HMO Help System. We strongly believe that the success of this system has helped to encourage HMOs to resolve potential cases earlier.

Of the 723 Independent Medical Review cases, 25 percent were based on instances where an HMO denied a service on grounds that it was experimental or investigational. Of these, 18 percent of the original denials were reversed. The remaining Independent Medical Review cases were based on instances where the HMO denied a service on ground that it wasn't medically necessary. Of these, 44 percent of the original denials were overturned.

Independent Medical Review Decisions



SUMMARY OF HMO HELP CENTER ACCOMPLISHMENTS

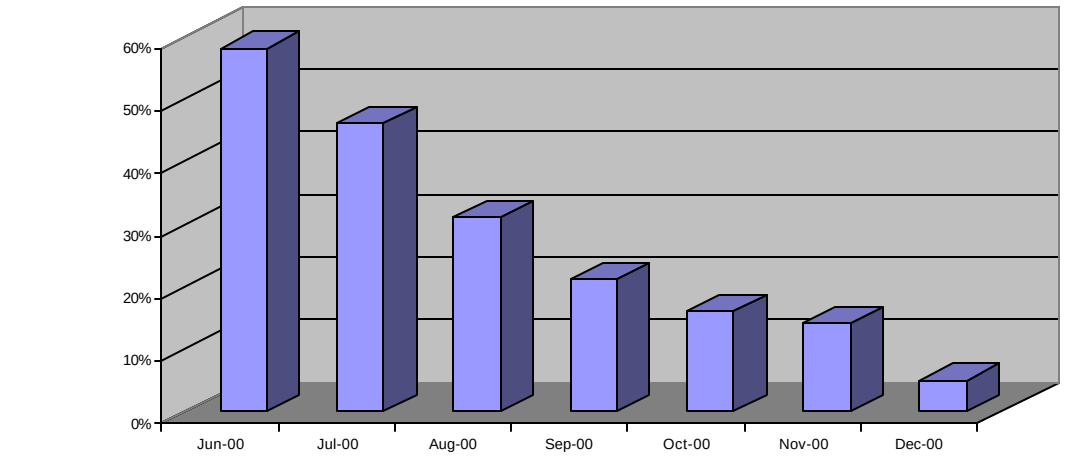
REDUCTION OF COMPLAINT BACKLOG

The Department of Managed Health Care (Department) was launched on July 1, 2000, assuming responsibilities formerly assigned to the Department of Corporations. As part of the transition process, the HMO Help Center began the task of resolving complaints against managed health care plans. As of July 1, 2000, the number of open complaints was 635 (over two months of incoming volume). In addition to the high volume of open complaints, over 58% of them had not been resolved within the 30-day mandate.

The HMO Help Center developed and implemented an aggressive plan to reduce the backlog of complaints and to reduce the percentage of complaints that exceeded the 30-day mandate. As a result of these efforts, by December 31, 2000, the backlog was reduced to 148 cases (approximately one-half of a month's volume) and the percentage of cases exceeding the 30-day mandate was reduced to 5%.

COMPLAINT BACKLOG REDUCTION – DATA

Below is a chart summarizing the effective resolution of this critical service issue for the first six months of HMO Help Center operation.



	June 30, 2000	July 31, 2000	August 31, 2000	September 30, 2000	October 31, 2000	November 30, 2000	December 31, 2000
Percentage Over 30 Days	58%	46%	31%	21%	16%	14%	5%

NEW AUTOMATED SYSTEM TO SUPPORT THE HMO HELP CENTER

The Department is dedicated to improving the quality of managed health care for consumers and helping to ensure the financial stability of the State's medical care delivery systems. In addition, the Department has a commitment to customer service. In order to maintain a high level of service, the Department implemented a new automated computer system.

There were four primary objectives that the new computer system was targeted to meet:

- **Improve Customer Service –** Develop a system that provides rapid access to case information, allows for aging and tracking of cases and workflow to ensure timely responses to consumer complaints, and provides the tools to capably assess a consumer's situation and respond immediately.

- **Improve Data Gathering and Reporting Capabilities –** Develop a system that allows the Department to gather the data necessary to identify systemic problems in the health care system so that changes can be made. In addition, assure that the system gathers data necessary to meet legislative and administrative expectations.

- **Increase Efficiency and Management Control –** Develop a system that eliminates manual processes, eliminates redundant tracking systems, increases staff productivity, and increases management control over work processes.

- **Improve Technical Foundation for the Future –** Increase the Department's ability to effectively and easily implement future technical solutions.

In December of 2000, the Department successfully completed implementation of the computer system to support the new Independent Medical Review program only six months after the Department began operation. By November of 2001, the system was expanded to support all HMO Help Center functions.

IMR PROGRAM & SYSTEM IMPLEMENTATION IN SIX MONTHS

The Department was launched in July of 2000. The legislation requiring the implementation of the new Independent Medical Review (IMR) program became effective on January 1, 2001. Within its first six months of operation, the Department completed the following tasks to assure effective implementation of the IMR program:

- Implemented a new computer system to support IMR case tracking, data collection, and aging.
- Designed all required forms.
- Designed and delivered training programs for Department staff and health plans.
- Designed and documented all processes, workflows, procedures and criteria (IMR billing and reimbursements and integration with Medi-Cal for example).
- Hired staff and developed the necessary infrastructure to support the new program.
- Screened and hired contractors.

STAFF TRAINING PROGRAM

In order for the HMO Help Center to be effective in assisting consumers through the maze of managed care, staff training became a critical area of focus. A detailed training plan was developed to assure that the program was comprehensive and implemented in a timely manner.

In addition, the HMO Help Center involved experts from a variety of organizations to assist with design, development and delivery of training: health plans, consumer advocacy groups, other State agencies and departments, counsel, etc.

The Health Rights Hotline provided instrumental support to our training and we are grateful for their leadership role in helping to ensure our success.

The training program included (but was not limited to) the following topics:

- Customer Service
- Knox-Keene Act
- Medical Terminology
- Effective Negotiating
- Managed Care 101
- COBRA
- New Legislation
- Referral Resources
- Dental "Managed" Care
- Effective Case Reviews

As a result of these training programs (and other efforts) the HMO Help Center is frequently contacted as a resource for general and referral information and has evolved into a true service organization.

INFRASTRUCTURE DEVELOPMENT

In order to be responsive to consumer needs, the Department focused energy and resources to make the HMO Help Center a centerpiece of its organization. To accomplish this, and to be prepared to assist consumers by July 1, 2000, the HMO Help Center:

- Installed a new telephone system, including: an Interactive Voice Response unit, a call center management information system which routes callers to the appropriate area for assistance; additional telephone lines; new toll-free telephone lines, including one concerning Provider issues; a Telecommunication Device for the Deaf; and assistance to callers in Spanish.

- Completely redefined the workflow and business processes to more effectively respond to consumer issues and complaints, focusing on ensuring resolution within the 30-day mandate.

- Hired and trained HMO Help Center staff to assist consumers via the telephone, additional staff to resolve complaints in a timelier manner, and additional counsel to review and resolve legal issues. An on-site nursing staff was hired to assist with a more efficient resolution of clinical issues, eliminating the need for constant referral to external clinical resources.

- Identified, procured, and set up a facility for the HMO Help Center that facilitates the receipt of inquiries and the processing of complaints and IMRs by consolidating the staff in one location. The call center, the complaint analysts, nurses and counsel can now easily discuss and resolve issues in a more timely manner. The new facility is readily accessible to any person who may want to pick up educational material, file a complaint or IMR in person, or speak to someone regarding the status of a current complaint.

CONSUMER ASSISTANCE PROGRAMS – GENERAL INQUIRIES & ASSISTANCE

An early priority defined by the Department of Managed Health Care focused on customer service. In addition to responding to formal complaints and processing requests for Independent Medical Review, the HMO Help Center responds to thousands of calls from consumers requesting general information or assistance. This section will describe the background, processes and types of general inquiries that the HMO Help Center receives.

BACKGROUND

The HMO Help Center receives from 10,000 to 17,000 calls each month from consumers, 5% of which result in a complaint or IMR. Calls are answered by the Interactive Voice Response system (providing general information, filing requirements for complaints and IMR, telephone numbers of major health plans and dental plans and DMHC's website address) or the staff of the HMO Help Center.

Consumers Require 24/7 Availability

An early issue identified by the HMO Help Center was the need to be available 24 hours a day, 7 days a week to respond to consumer issues. Health care problems often occur outside of regular business hours and consumers need a resource to assist them during this time.

If a consumer contacts the HMO Help Center with an urgent issue after regular business hours (7:00 a.m. – 6:00 p.m.), the call is forwarded to a HMO Help Center attorney or nurse for immediate response. (For more information on what constitutes an "urgent issue" please refer to the section titled "Types of Contacts" – "Urgent Issues.") The HMO Help Center maintains a list of health plan staff that can be reached during non-business hours to resolve these urgent issues.

Non-urgent calls after the HMO Help Center's regular business hours are answered by an external call center agent who provides general information, sends a variety of forms, and initiates the complaint resolution process. More complex issues may be deferred to the next business day.

Information Available in Multiple Languages

The HMO Help Line provides services for those consumers who have limited English language abilities. The HMO Help Center provides a special phone line for Spanish-speaking consumers that is staffed by bi-lingual staff. The HMO Help Center also provides for telephonic translation services for over 100 languages. In addition, numerous HMO Help Center forms and materials are translated into Spanish and Chinese with translations in additional languages anticipated in the future.

HMO Help Center Services for our Hearing Impaired Consumers

The HMO Help Center has a Telecommunication Device for the Deaf (TDD) on-site and available during regular business hours. Hearing-impaired consumers can call the HMO Help Center using the toll-free TDD line at (877) 688-9891 or by using the California Relay Service. In addition, HMO Help Center Agents have been trained in sign language and are available on-site to assist our hearing-impaired consumers.

CONSUMER LINE – CULTURAL LINGUISTIC CALLS – DATA

Total Calls – The total call volume received on the consumer helpline during 2001.	**171,182**
Spanish Calls – The total number of calls where the consumer selected the option to hear information in Spanish. Of these calls, 4,003 were assisted through the IVR; the remaining 3,989 spoke to a DMHC Spanish-speaking agent.	**7,992**
Language Line – The total number of calls for which HMO Help Center Agents utilized the AT&T Language Line interpretation services. (This program offers interpretation services for over 100 languages.)	**13**
TDD Calls – The total number of callers who called our special TDD line for the hearing impaired.	**191**

Automated Responses to Inquiries

When a consumer calls the HMO Help Line at (888) HMO-2219 they can always reach a live person to assist them. However, the HMO Help Center's automated system provides telephone numbers for the major health and dental plans, general information regarding the HMO Help Center, filing requirements for complaints and IMRs, and the Department's website address where consumers can obtain additional information.

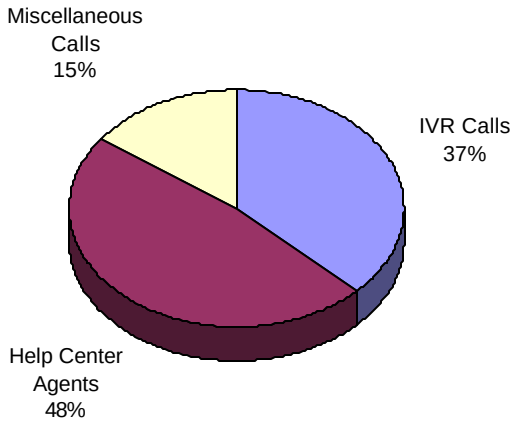
PROCESSES

Consumers generally contact the HMO Help Center by telephone. However, the HMO Help Center also receives correspondence, e-mails, faxes, and walk-in visits from consumers.

When contacting the HMO Help Center by telephone, consumers select from a list of options to get the specific assistance they require. The options are:

- Direct referral to Spanish-speaking Agents
- Automated access to health plan telephone numbers
- Direct referral to an Agent regarding a problem
- Direct referral to the HMO Help Center clinical team for urgent issues requiring immediate attention
- Direct referral to an Agent who can take an application for Independent Medical Review (IMR) over the phone
- Direct referral to an Agent regarding denial of benefits
- Direct referral to an Agent regarding the status of a complaint or IMR

Calls Answered by the HMO Help Center in 2001



CALLS ANSWERED BY THE CALL CENTER – DATA

The chart identifies the total call volumes received on the HMO Help Center consumer line and how the calls were answered. The following is a brief explanation of the categories.

Total Calls – 171,182
The total call volume received on the consumer helpline during 2001.

IVR Calls – 63,631
The total number of calls that were answered by the HMO Help Center's automated voice response system (IVR) in 2001**.**

HMO Help Center Agents – 84,069
The total number of calls that were answered by the HMO Help Center Agents.

Miscellaneous Calls – 23,482
The total number of calls that were answered on the Provider Line, the TDD Line, or abandoned by the caller.

TYPES OF CONTACTS

General Inquiries

General inquiries cover a wide range of issues, the most frequent of which are described below:

♦ **Health Plan Contact Information –** Many consumers contact the Department to get the telephone number, address, and/or contact name for a health plan.

♦ **Medical Group Closures / Contract Terminations –** Throughout the year, the HMO Help Center assists many consumers impacted by a medical group going out of business or terminating their association with a health plan. HMO Help Center Agents outline consumers' rights under a contract termination, answer questions regarding the transition to a new medical group or take appropriate action if the transition has not yet occurred.

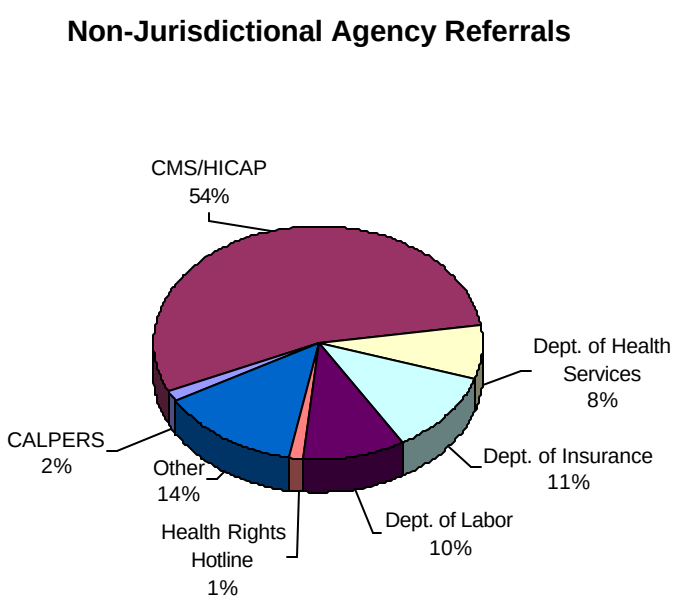
♦ **Health Plan Bankruptcy or Withdrawal from Service Area –** The HMO Help Center assists consumers impacted by a health plan bankruptcy or a health plan withdrawal from a service area. Similar to calls regarding the closure of a medical group, HMO Help Center Agents answer questions regarding the transition process.

♦ **"Non-Jurisdictional" Calls –** A number of consumers who contact the Department for assistance actually require referral to another department or agency for assistance. For example, a consumer covered by an employer self-insured plan must call the Department of Labor or a consumer covered by an indemnity health insurance plan must call the Department of Insurance. HMO Help Center Agents provide the consumer with contact information for the appropriate agency.

♦ **Community Resource Referrals** – If necessary, the HMO Help Center will provide referrals to community resources in order to assist a consumer. Preventive health care information is also made available to consumers in an effort to promote wellness.

♦ **General Education –** The HMO Help Center frequently plays an educational role when talking with consumers. In these instances, the HMO Help Center describes the role of the Department of Managed Health Care and the HMO Help Center, outlines the complaint and Independent Medical Review process, defines the consumer's responsibility in resolving issues with their plan, provides referrals to the Department website, or assists the consumer with other issues.

♦ **Status Calls –** Consumers will often contact the HMO Help Center to get information on the status of their complaint or Independent Medical Review. These calls are referred to the HMO Help Center staff member who is handling the consumer's case.



NON-JURISDICTIONAL REFERRALS – DATA

The chart identifies those agencies that receive the largest number of referrals from the HMO Help Center. This data is captured in the new computer system, which was implemented November 15, 2001. (Therefore, these numbers reflect the requests received from November 15 through December 31, 2001, only. They may not be reflective of the referrals for the previous months.)

Requests for Information

Consumers often contact the HMO Help Center to request informational pamphlets, forms or specific sections of the Knox-Keene Act. This information is sent to the consumer or is obtained from the Department of Managed Health Care's website at www.hmohelp.ca.gov. The most frequently requested materials include:

♦ **The Patient Guide** – This guide was prepared through a consolidated effort between the Foundation for Taxpayer and Consumer Rights, the California Wellness Foundation, the Department of Consumer Affairs and the Department of Managed Health Care. The guide is intended to inform consumers of their rights to receive quality health care and what steps they can take if they encounter problems.

♦ **Complaint Form** – The Department of Managed Health Care form that a consumer completes if not satisfied with the health plan's resolution or if the health plan does not resolve the issue within 30 days.

♦ **Independent Medical Review Application** – The Department of Managed Health Care form that a consumer completes to apply for an Independent Medical Review.

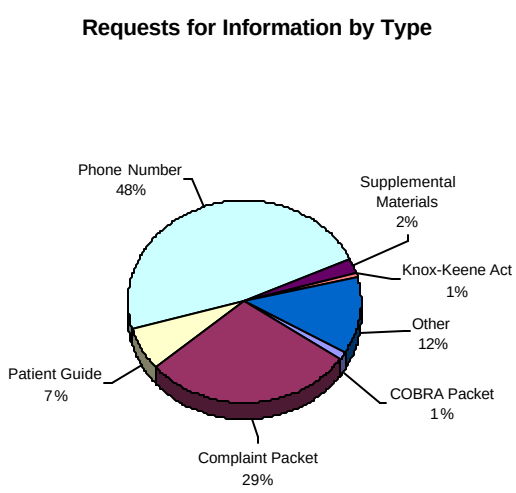
♦ **Knox-Keene Act Sections** – The Knox-Keene Health Care Service Plan Act of 1975 is the set of laws passed by the State Legislature to regulate HMOs within California.

♦ **List of Licensed Health Plans** – This list provides the address, contact information, and licensing information for all licensed health plans.

♦ **HMO Report Card** - Prepared by the Office of the Patient Advocate, the HMO Report Card rates HMOs on quality and service with the goal of helping consumers choose the HMO that best meets their family's health care needs.

♦ **Health Care Service Plan Complaint Data Report** – This annual report submitted to the Legislature details the numbers and types of complaints or grievances received by the Department during the calendar year. (Starting with this 2001 report, the report will also include information on the number of Independent Medical Reviews and general inquiries received by the Department.)

♦ **California COBRA Information** – Cal-COBRA provides patients the right to keep their group coverage at the same premium rates as the employer group under certain conditions when it might otherwise end. Consumers can obtain general information on eligibility requirements, benefits and other program information from the Department's website.



REQUESTS FOR INFORMATION – DATA

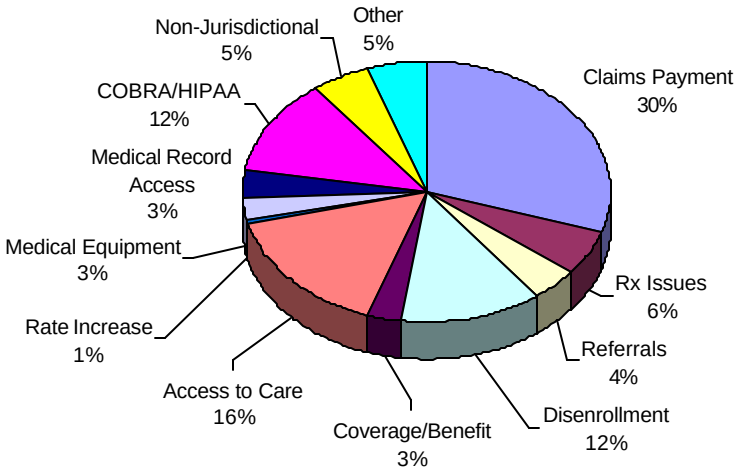
The chart identifies the most frequently requested information. This data is captured in the new computer system, which was implemented November 15, 2001. (Therefore, these numbers reflect the requests received from November 15 through December 31, 2001, only. They may not be reflective of the requests for the previous months.)

Quick Resolutions

The HMO Help Center initiated a program to resolve problems through a three-way conference call with the health plan, the consumer and a HMO Help Center Agent. The goal of this program is to quickly resolve problems before they become formal complaints or need to go to Independent Medical Review. This program is the result of the HMO Help Center's experience that many issues can be resolved by opening the lines of communication between the plan and the consumer and assisting the consumer in understanding their health care rights and responsibilities.

This program is completely voluntary for both plans and consumers. If either decides to pursue the issue via a formal complaint or Independent Medical Review, the issue is immediately transitioned from the Quick Resolution process to the appropriate alternative dispute resolution process.

Quick Resolution Issues



QUICK RESOLUTION – DATA

The HMO Help Center worked with consumers to resolve **905** cases through the Quick Resolution process from January 1 through December 31, 2001. The chart identifies the types of issues that were addressed.

Data available from the new computer system (implemented November 15, 2001) also provides the following information regarding the resolution timelines of complaints:

- Of the 38 Quick Resolution cases closed from November 15 through December 31, 2001, issues were resolved in an average of one calendar day.

Urgent Issues

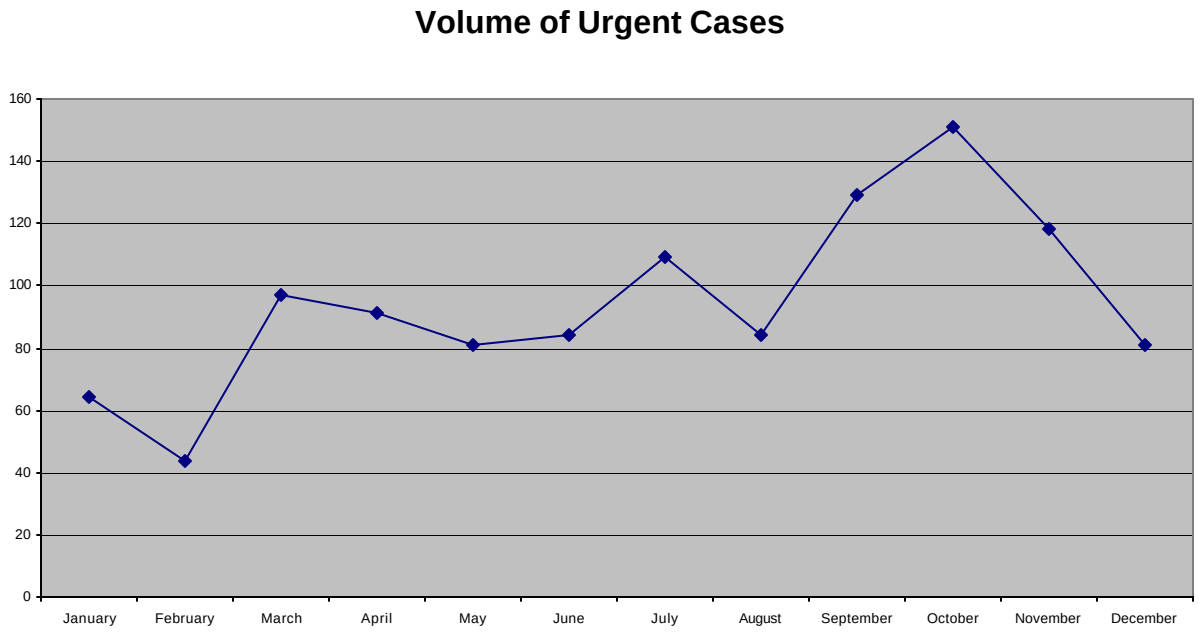
Consumers often call the HMO Help Center with issues that cannot wait 30 days for the formal complaint process. These complaints often involve issues of delays or denials in re-filling prescription medications, delays in obtaining appointments or surgery for pressing health care issues, premature release from a hospital or facility, and inability to obtain a referral for treatment.

Urgent issues are generally referred to Department nurses who work with the consumer and the health plan to resolve the issue. Department staff is available 24 hours a day, 7 days a week to resolve urgent issues. The Department also maintains a list of health plan contacts that must also be available 24 hours a day, 7 days a week to support resolution of these urgent issues.

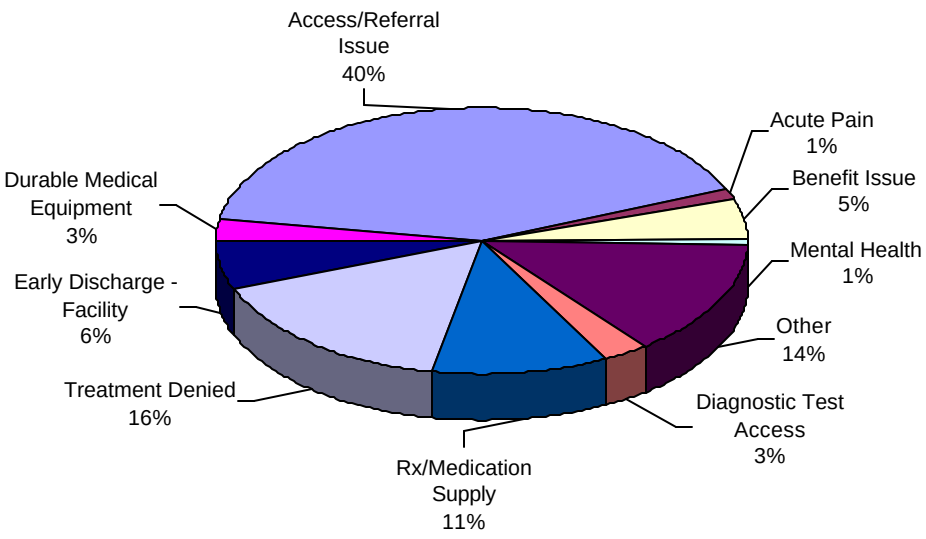
If the nurse determines that the consumer does not require urgent assistance, the consumer's dispute is referred to the complaint or IMR process for resolution.

URGENT COMPLAINT VOLUME – DATA

The chart below identifies the total number of Urgent requests that the Department received in 2001. The total volume for 2001: **1,133.**



Urgent Complaint Issues



URGENT COMPLAINT TYPES – DATA

Data available from the new computer system (implemented November 15, 2001) provides detailed information on urgent complaint issues. (The chart summarizes volumes received from November 15 through December 31, 2001, only. These issues may not be reflective of the issues resolved in the previous months.)

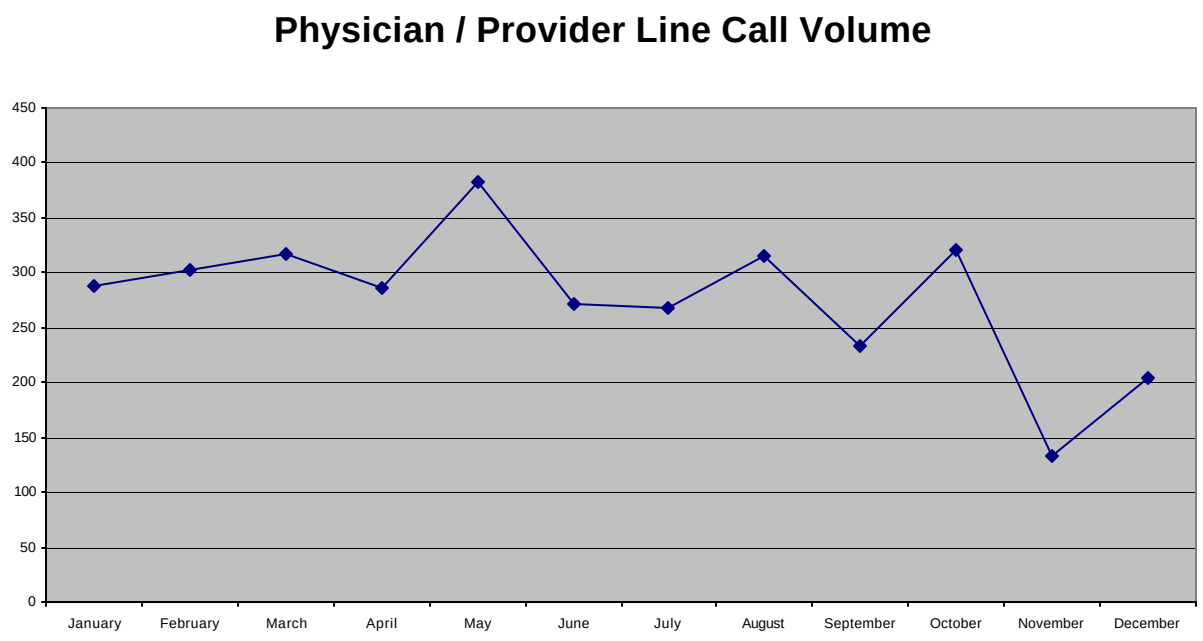
Physician Calls

Physicians and other medical professionals use the toll free Provider Line at (877) 525-1295 to notify the Department of complaints regarding a health plan or medical group. The majority of complaints received from providers are regarding claim payment delays and denials. The information gathered from these complaints contributes to on-going oversight activities by identifying systemic problems, which are then addressed with health plans or medical groups by the Department's Director of Plan and Provider Relations.

Physicians may also call the Department on behalf of their patients. These calls are referred to the appropriate consumer dispute resolution process.

PHYSICIAN / PROVIDER LINE – DATA

The chart below identifies the total call volumes received by month on the HMO Help Center physician/provider helpline. The total volume for 2001: **3,321**.



ISSUES & CHALLENGES – GENERAL INQUIRIES

The HMO Help Center faces the following challenges related to general inquiries.

Real Time Issues

One of the biggest and perhaps one of the most important challenges facing the HMO Help Center is how to best utilize the wealth of data collected via our new computer system. Beginning with the incoming calls to the final resolution of complaints or IMRs, the opportunity exists to capture information regarding "real time" issues facing today's consumers. With this data the HMO Help Center can alert other areas of the Department to enforcement issues, leads for medical surveys, and non-compliance with licensing requirements. In addition, this data can assist the Office of the Patient Advocate with vital areas of consumer concerns and needs, allowing them to more effectively focus their outreach efforts.

The Department has been directed by the Legislature to be proactive in defining health care risks for consumers by identifying potential patterns in consumer complaints that would indicate provider, plan and industry issues. The Department has focused on the HMO Help Center as a vital component in meeting this directive.

Data Integrity

The reliability and consistency of data is of utmost importance with any new system, especially when there is a possibility that it may be used to make statewide health care decisions. Therefore, staff will be thoroughly trained and continually monitored for adherence to established procedures and policies. Data fields will be analyzed for accuracy and for verification that staff are correctly entering data. Also, numerous security measures have been added directly to the system, including the provision that only specific individuals have the ability to change or delete records, thereby ensuring the integrity of the information.

Outreach Efforts Increase Awareness of the HMO Help Center

The Department is actively pursuing outreach efforts to make California consumers aware of the assistance available through the HMO Help Center. These efforts will likely result in increased call volumes; the HMO Help Center's challenge is to maintain the ability to respond to the increasing needs within budgetary constraints.

Training HMO Help Center Agents

High turnover is a consistent issue for the modern call center. The HMO Help Center Agents must receive extensive training to understand and explain the complex managed care system. Retaining well-trained Agents under normal vacancy rates is a constant challenge.

CONSUMER ASSISTANCE PROGRAMS: THE COMPLAINT PROCESS

The consumer complaint process responds to issues of benefit and coverage disputes, claims and billing problems, eligibility, inadequate access to care, attitude or service concerns, and quality of care concerns. (Disputes regarding denials of service may qualify for Independent Medical Review, which is defined in the next section.)

Although this dispute resolution process has been in place for some time, the HMO Help Center has developed the infrastructure necessary to make the process more responsive to California HMO consumers.

BACKGROUND

A complaint is a grievance against a health care service plan that has been received by the Department's HMO Help Center. These complaints are researched and resolved by a team of HMO Help Center staff that includes Consumer Service Representatives, Analysts, Counsel, and Clinical Staff.

Before a complaint is eligible for review by the HMO Help Center, the health plan, through its grievance and appeals process, must have had an opportunity to assess and resolve the issue within 30 days (or 72 hours for expedited grievances).

A consumer may submit a complaint to the Department by telephone, letter, e-mail, or by completing a *Consumer Complaint Form* which is available on the Department's web site at www.hmohelp.ca.gov. Though it is not a requirement to complete the *Consumer Complaint Form*, it does facilitate the complaint resolution process by assuring that the HMO Help Center receives all the information necessary to resolve a complaint. The complaint process consists of a review of all written information provided by both the consumer and the health plan, including relevant medical records if necessary. Complaints are generally resolved by the HMO Help Center within 30 days. There is no charge to the consumer for submitting a complaint to the HMO Help Center for resolution.

The HMO Help Center issues a written explanation of the decision. If the complaint is resolved in the consumer's favor, the health plan will be required to provide the disputed service, pay for the disputed service or take other appropriate action (as defined by the Department). If the complaint is not resolved in the consumer's favor, the consumer may pursue legal action as defined in the plan's *Evidence of Coverage*.

PROCESSES

Initial Review

Because of the volume and variety of issues forwarded to the Department, the HMO Help Center has established an Initial Review Unit. This team is responsible for reviewing all written requests submitted to the Department, determining the urgency, identifying the appropriate dispute resolution process (such as IMR, Complaint, Urgent, Early Review, Provider) and acknowledging receipt of the request.

Information received and screened by the Initial Review Unit is forwarded to the appropriate analyst for processing. On average the unit receives 1,200 written requests (correspondence, fax, e-mail, etc.) per month, approximately 500 of which are assigned to one of the dispute resolution

processes. The remainder are resolved by the Initial Review Unit which prepares correspondence and provides direction on how to navigate the HMO grievance and appeals process.

In addition to cases that are within the Department's jurisdiction, a significant percentage of requests for assistance received by the Initial Review Unit are not within the Department's jurisdiction. As a result, the Initial Review staff are required to have a full knowledge and understanding of programs sponsored by other State and Federal agencies and advocacy groups in order to refer the requests to the appropriate organization. This unit consistently refers consumers to the following organizations:

- U. S. Department of Labor
- Health Insurance Counseling & Advocacy Program (HICAP)
- U. S. Office of Personnel Management (OPM)
- California Public Employees' Retirement System
- Department of Health Services
- California Department of Insurance
- Center for Medicare and Medicaid Services (CMS)
- California Department of Consumer Affairs Dental & Medical Boards
- Major Risk Medical Insurance Board (MRMIB)

Finally, data on all incoming complaints, regardless of type, is entered into the Department's automated tracking system. The Initial Review Unit ensures accurate data collection and maintenance of the automated tracking system.

Referrals to the Health Plan (also known as Refer to Plan)

If the Initial Review Unit determines that the consumer has not yet participated in the health plan's grievance and appeals process for the required 30 days, the complaint is forwarded directly to the health plan for resolution.

The HMO Help Center also notifies the consumer that if the health plan does not resolve their dispute within the required 30 days or if they are not satisfied with the resolution, they may contact the HMO Help Center to initiate a complaint.

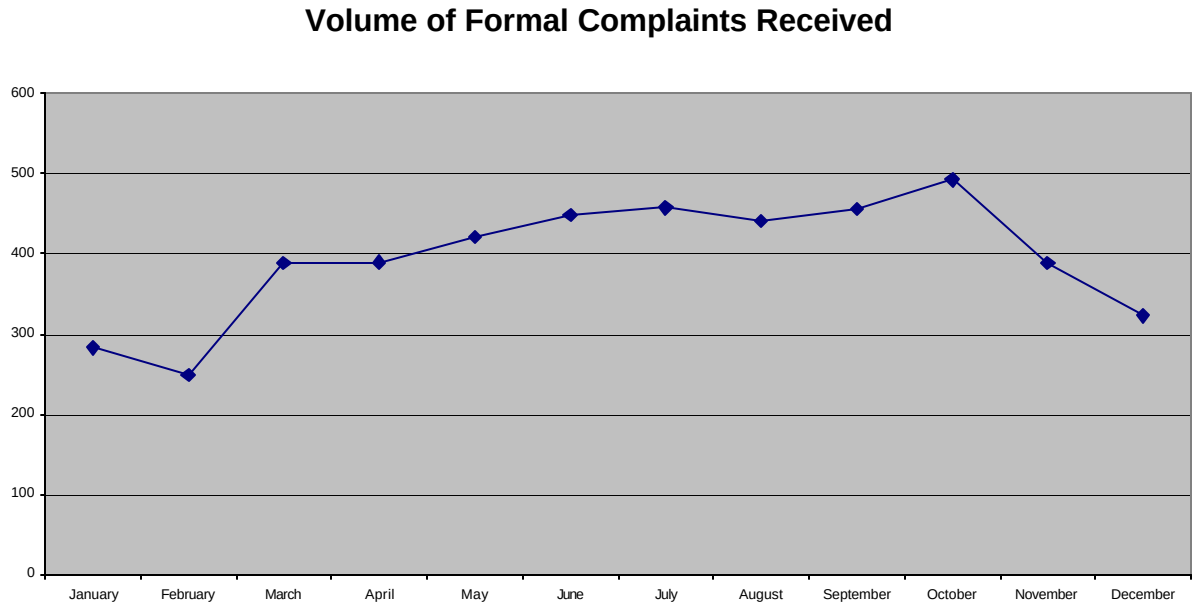
Formal Complaints

When a complaint is assigned to a Complaint Analyst by the Initial Review Unit, the analyst must gather relevant facts and supporting documentation and inform the consumer of the Department's intended action. The analyst coordinates efforts between health plan administrators and HMO Help Center clinical and legal staff to resolve the complaint. This often results in negotiations with HMO legal representatives and other organizations. The analysts maintain cooperative working relations with the Office of the Patient Advocate, the Major Risk Medical Insurance Board, the Health Insurance Counseling and Advocacy Program, the Department of Health Services Medi-Cal program administrators, and the Department of Insurance to research and resolve complex cases. Reports of discovery and resolution are shared with the appropriate organization when necessary.

Regardless of the outcome, the consumer is notified of the Department's decision in writing.

The Complaint Unit focuses on effectively resolving complaints in order to minimize referrals to the Department's Office of Enforcement, Division of Plan Survey and Division of Licensing within the Office of Health Plan Oversight. However, if systemic problems are discovered as a result of multiple complaints, the issues are referred to the appropriate office for further action.

VOLUME OF FORMAL COMPLAINTS RECEIVED – DATA
From January 1, 2001 through December 31, 2001, the Department received **4,740** formal complaints. Below is a summary of the volume of complaints received by month. (This does not include IMRs.)



Early Review – Legal Complaints

A complaint will be treated as an "Early Review - Legal Complaint" if the consumer is involved in a time sensitive dispute that requires intervention prior to the 30-day mandate. Examples of these types of reviews include:

- HIPAA, Cal-COBRA, or Senior COBRA deadline issues
- Cancellation of coverage deadline issues
- Continuity of care issues involving a severe medical condition that requires the consumer to receive care from the same physician or medical group for a specified period of time
- Health plan delays in implementing Department determinations

If research determines that the issue is not critically time sensitive, it will be referred to the normal complaint process to be resolved within 30 days.

Complaint Compliance Determinations

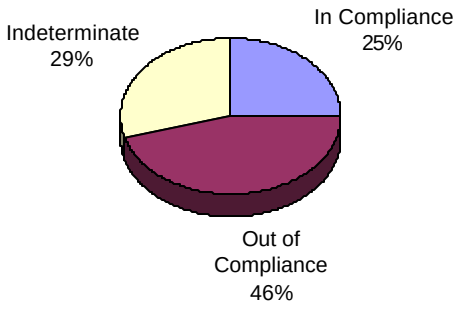
Upon resolving a complaint, HMO Help Center staff assign a compliance determination. The following are descriptions of the compliance determinations.

- **In Compliance –** Based upon Counsel's review of complaint documents (including the health plan's response to the complaint), no specific violation of the Knox-Keene Act or corresponding regulations was found.
- **Out of Compliance –** Based upon review of complaint documents (including the health plan's response to the complaint), Counsel has identified a specific violation of a section of the Knox-Keene Act or corresponding regulations.
- **Indeterminate –** This determination is used in two scenarios: 1) there is insufficient evidence to indicate non-compliance on the part of the health plan, or 2) a compliance determination may not be applicable.

Compliance With Patients' Rights Laws

COMPLIANCE WITH PATIENTS' RIGHTS LAWS – DATA

This chart identifies the percentage of compliance determinations in each category for complaints resolved in 2001.



Health Plans Uphold or Overturn Initial Determination

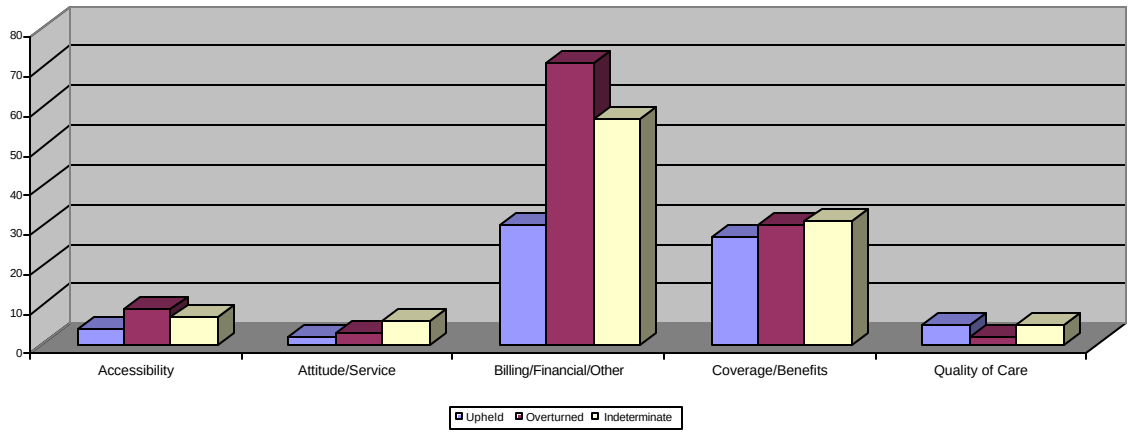
The new computer system allows the HMO Help Center to capture information regarding whether the health plan upholds or overturns its initial decision. A compliance determination is made by HMO Help Center staff based upon review of complaint documentation. Uphold and overturn decisions are made by the Health Plan as the result of the complaint process. (For example, a complaint regarding a grievance that was not completed by the health plan within the 30-day mandate may result in a determination of "out of compliance," but may not require the health plan to overturn the grievance determination.)

- **Upheld –** The health plan upheld their original denial (in accordance with the applicable Evidence of Coverage or Knox-Keene Act section).
- **Overturned –** The health plan overturned their original denial.
- **Indeterminate –** The case does not warrant a decision to uphold or overturn the health plan. (Examples include: a complaint regarding the quality of care received or a complaint about a claim payment delay.)

COMPLAINTS UPHELD VS. OVERTURNED – DATA

This data is captured in the new computer system that was implemented November 15, 2001. (Therefore, these numbers reflect complaints that were opened and closed from November 15, 2001 through December 31, 2001. They may not be reflective of the requests for the previous months.)

Complaint Determinations by Issue



AVERAGE RESOLUTION TIMEFRAME – DATA

Data available from the new computer system (implemented November 15, 2001) provides the following information regarding the resolution timelines of complaints:

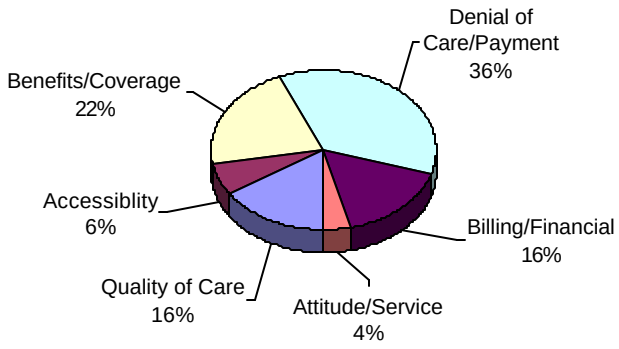
- Of the 296 cases closed from November 15 through December 31, 2001, complaints were resolved in an average of 14 calendar days.

TYPES OF COMPLAINTS

The Complaint Unit researches and analyzes the following types of complaints.

COMPLAINT TYPE SUMMARY – DATA

The chart provides a summary of Complaint categories for Complaints received in 2001.



COMPLAINT TYPE DEFINITIONS
Accessibility Complaints These complaints include: long wait times for appointments, lack of availability of primary care or specialty physicians, failure to respond to patient requests, etc.
Coverage & Benefits Disputes These complaints include: disagreement about whether a service is covered under the member's evidence of coverage; denials on the basis that benefit maximums have been reached, etc.
Appeals of Denials or Payment These complaints include: health plan refuses to authorize care or changes patient to a lower level of care, denials of care on the basis that it is experimental or investigational, denials of payment for emergency or urgent services received, refusals to refer to a specialist or ancillary services, refusals to pay for medical services or durable medical equipment, etc.
Quality of Care These complaints include: complaints about the physical condition of a hospital or physician office, complaints about inappropriate care by a hospital or physician (failure to diagnose or treat), etc.
Billing & Financial Disputes These complaints include: disputes regarding disenrollment or termination of coverage, complaints about false or misleading marketing information, claims disputes (including slow payment and insufficient payment), premium disputes (including refund requests and premium increases), etc.
Attitude & Service These complaints include: complaints about health plan, physician or office staff behavior (including attitude, communication, rudeness), complaints about slow responses to inquiries, etc.

Monetary Benefits for Consumers

Consumers often contact the Department when they are being charged for services that they feel should be covered by the health plan. The amount of money consumers have saved in 2001 as a result of HMO Help Center intervention was **$1,846,497**. The amount reflects claims disputes that expressly identified a dollar reimbursement. The amount reported does not include non-reimbursable costs associated with surgery or other procedures that were initially denied by the health plan, but were later authorized by the health plan.

ISSUES & CHALLENGES - COMPLAINTS

The HMO Help Center faces the following challenges related to consumer complaints.

Staffing to Meet the 30-Day Resolution Deadline

A key challenge facing the HMO Help Center is dealing with the State restrictions on hiring and the limitation of funding and budgetary positions. As complaint volumes increase, this impacts the ability to hire the number of staff required to meet the 30-day resolution mandate. This is further complicated by the complexities of investigating, evaluating and resolving complicated, multi-faceted complaints within a 30-day general timeframe.

Health Plans Encouraging Consumer Participation in the Grievance Process

Effective and accurate communication between enrollees and their plans is critical to the effectiveness of the grievance process. In discussions or correspondence between the plan and the enrollee concerning a dispute, the plan should immediately and clearly notify the enrollee of the right to file a grievance.

Often consumers who have contacted their medical group or health plan to resolve a problem, have not been made aware of the plan's formal grievance and appeals process. As a result, a consumer may be attempting to resolve a problem informally for quite some time before they begin to use the plan's grievance process.

The Department may allow the consumer to participate in the complaint process without a grievance determination if the consumer has been attempting to resolve the issue, either informally or formally, with the health plan (or medical group) for longer than 30 days.

Consumer Education and Awareness

The Department advocates ongoing consumer education related to health care rights, responsibilities and options in accordance with the law and the terms of the various health care plans.

Additionally, fragmented levels of responsibility in the delegated network managed care model results in consumer misunderstanding, frustration and the need to engage in complex, time-consuming problem resolution processes.

Finally, communications at all levels within the managed health care delivery system, beginning at the physician's office and continuing through the health plan's responses to consumer grievances, contain minimal levels of explanation and information and that contributes to the consumer's difficulty in understanding the system.

Health Care Service Delivery Disruptions

Facilitating access to care in an unstable marketplace is an enormous challenge for the HMO Help Center. Plan and provider contract disputes, as well as plan withdrawals from service areas, result in the need to constantly monitor for potential disruptions to health care service delivery and to intervene for consumers in rapidly changing situations.

Prescription Drug Coverage

The Department's authority in the area of prescription drug coverage was recently limited by a court decision. This increases the complexity when Department staff

evaluate denials of prescription drug coverage where the Department's regulatory authority is at issue and coverage rules are complex and vary widely from plan to plan.

Governor Davis recently signed into law SB842, which restores the Department's authority over prescription drugs.

The Evolution of Managed Care

Due to the requirements of applying existing law to new, unanticipated situations, the Department is challenged to keep pace with the rapidly changing managed care environment. Regulations as currently written did not and could not contemplate the numerous changes that continue to occur in the managed health care delivery system.

CONSUMER ASSISTANCE PROGRAMS: INDEPENDENT MEDICAL REVIEW (IMR)

BACKGROUND

On January 1, 2001, California's Independent Medical Review law went into effect. Independent Medical Review (IMR) allows consumers who have been denied treatment or medical care to have those decisions reviewed by physicians or other appropriate medical professionals who are not affiliated with their health plans.

Three types of disputes with health care service plans are eligible for IMR:

- Denials based on a finding that a requested therapy is experimental or investigational for life-threatening or seriously debilitating medical conditions; and

- Services that are denied, delayed or modified by the health plan or one of its contracting medical providers based on a finding that the service is not medically necessary;

- Disputes concerning a health plan's failure to reimburse the consumer for out-of-plan emergency or urgent medical services.

Under sections 1374.30 through 1374.36 of the Health and Safety Code, the Department determines whether the case involves an issue that is eligible for a medical necessity IMR. Before an IMR application is eligible for review, the health plan, through its standard grievance process, must have had an opportunity to assess and resolve the issue within 30 days, or 72 hours for expedited requests (unless the services were denied under an experimental/ investigational exclusion, for which the grievance requirement does not apply).

Requests for IMR are received and processed by the Department's HMO Help Center in Sacramento by a team comprised of Complaint Analysts, a Health Analyst, Nurses, and Counsel. Because IMR cases may be received by telephone, e-mail, or correspondence, knowledge of the IMR system and processes is a shared responsibility of a large number of HMO Help Center staff.

There is no charge to the consumer for the application or the processing of an IMR. The health plan is assessed a fee based on the type of case, the number of reviewers, and whether the determination must be expedited.

The new IMR system and structure is a fully integrated part of the Department's focus on resolving consumer complaints with health plans as expeditiously as possible through its clinical, legal and consumer assistance staff.

PROCESSES

Since the IMR program's inception in January 2001, the HMO Help Center has implemented and refined the processes surrounding the receipt and processing of IMR cases. These processes are described below.

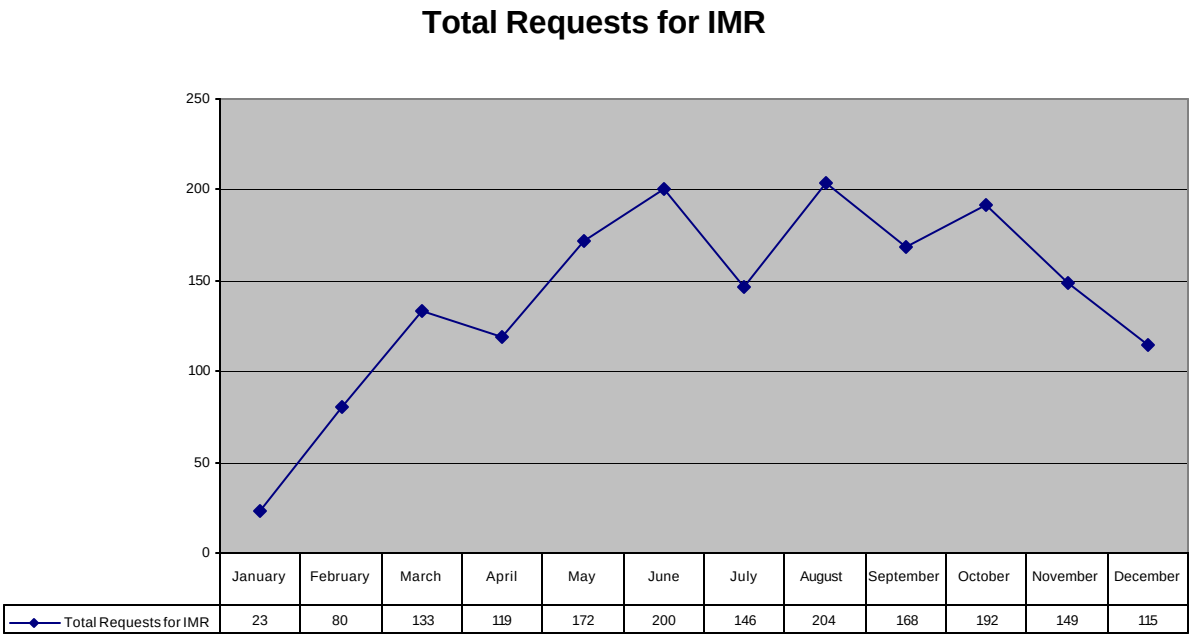
Consumer Awareness of IMR

Information about the IMR process and how to contact the Department is set out in the health plan's evidence of coverage and in the health plan or medical group's initial denial letters. At the time a health plan

makes a final determination on a grievance that denies, delays or modifies the requested health care service, the plan must send the consumer an IMR application with an envelope addressed to the Department. The application form, as well as other materials related to the IMR system, were developed by the Department and distributed to the health plans. (These materials and additional information about IMR are also available in Spanish and Chinese and can be found on the Department's Internet website at www.hmohelp.ca.gov and from the HMO Help Center.)

TOTAL VOLUME OF IMR REQUESTS – DATA

From January 1, 2001, through December 31, 2001, during the first year of the IMR program, the Department received **1,701** requests for independent medical review. Below is a summary of the volume of IMR requests received by month.



IMR Application Processing

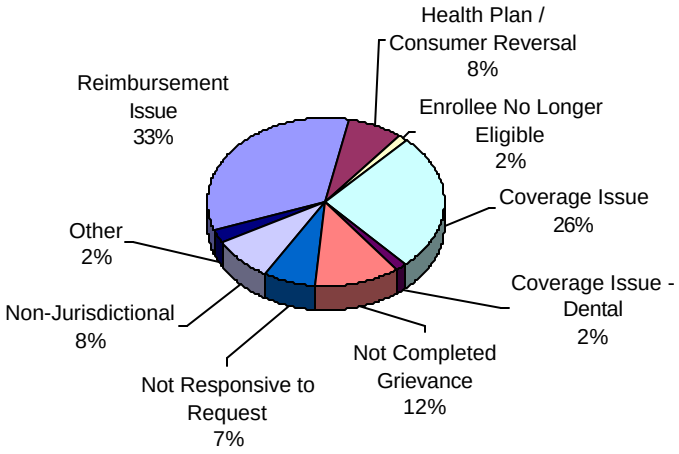
All consumer inquiries and complaints, including applications for IMR, are received at the HMO Help Center and reviewed by the Initial Review Unit to determine whether an issue presented by a consumer is eligible for an IMR. Some requests originally considered for IMR ultimately do not meet the criteria for the program. In these cases, the request for IMR is rejected as ineligible and a letter is sent to the consumer advising them of other options available to assist them. If the request for IMR does meet the eligibility criteria, it is accepted and "qualified" for independent medical review.

Requests may be received by phone call or mail. If additional information is required to determine eligibility, the information is obtained by phone or fax with the consumer, health plan or providers, as necessary. In time-sensitive cases and requests for expedited IMRs, clinical nursing staff is consulted to attempt an immediate resolution of the dispute.

Full-time nursing staff and counsel at the HMO Help Center review prospective cases, address clinical questions and ascertain whether a dispute pertains to coverage or medical necessity issues. In addition, an attorney reviews the entire case file and IMR determination prior to its adoption by the Department. While they are in the review process, Complaint Analysts are responsible for tracking IMR cases. A program manager is responsible for overseeing the program's day-to-day operations and the overall coordination of the IMR program with the independent medical review organization (Review Organization).

Requests for IMR must be submitted by consumers to the Department within six months of receiving a denial from the health plan.

Reasons IMR Requests Not Eligible



REASON REQUESTS FOR IMR NOT ELIGIBLE – DATA

Based upon the Department's initial screening process, the Department rejected **978** Independent Medical Review cases that were originally considered possible IMRs. The reasons that the cases were determined ineligible are summarized on the chart.

REASON IMR REQUEST NOT ELIGIBLE
Reimbursement Issue The services were already rendered. Includes medical services obtained by consumer out-of-network; consumer not obtaining a prior authorization; etc. These cases are referred to the Department's Complaint process for resolution.
Coverage Issue The disputed service was a specific exclusion of the Evidence of Coverage.
Dental Issue Dental issues are not eligible for the IMR process.
Had Not Completed Plan Grievance This applies only to requests for Medical Necessity IMRs where the patient is required to participate in the health plan's grievance process prior to requesting an IMR.
Non-Jurisdictional Consumer's health plan is under the jurisdiction of another agency (Department of Insurance, Medicare, etc.).
Not Responsive to Request The patient or physician did not respond to requests by the Department for additional required information.
Health Plan / Patient / DMHC Reversal Health plan or patient withdrew their request for an independent medical review prior to submission to the Review Organization (62 cases) or the issue was resolved through intervention by Department clinical staff (12 cases).
Enrollee No Longer Eligible The enrollee was no longer eligible for services from the health plan (e.g. termination of coverage).
Other Other reasons that cases were determined to be ineligible include: the six-month deadline to file an IMR application had passed; plan actions and denials occurred before January 1, 2001; a Medi-Cal beneficiary had utilized the Fair Hearing process or was requesting review for a non-covered service; or the condition was not life-threatening or seriously debilitating (for experimental/ investigational reviews).

Notifications Following Application Screening & Processing

If an IMR application is determined to be eligible and complete, HMO Help Center staff contact the health plan, the applicant, and the Review Organization.

♦ **Health Plan -** The HMO Help Center provides the health plan with the name of the Review Organization and directs the health plan to submit medical records to the review organization (1) within three business days for a standard review and (2) within 24 hours for an expedited review. The Department provides the health plan with a copy of the independent medical review application, independent medical review acceptance letter, release of medical records form, and other necessary documents.

♦ **Applicant -** An independent medical review acceptance letter is sent to the applicant advising that the case has been assigned to a specific Review Organization. The applicant is advised that all materials from the health plan will be sent to the Review Organization and that any additional information from the applicant must be submitted immediately to the Review Organization.

♦ **Independent Medical Review Organization -** The Department sends the application and other pertinent information to the Review Organization by courier or fax. The Review Organization is responsible for requesting additional information from the health plan.

Referral to the Independent Medical Review Organization & Selection of Reviewers

Eligible cases are referred to the primary IMR Organization (Review Organization) which provides its services under a contract with the Department. Following acceptance of an IMR application, the HMO Help Center notifies the Review Organization electronically (through the new computer system that was implemented to support the IMR process) to determine its availability to accept the case. The Review Organization performs an internal conflict of interest check and contacts prospective reviewers.

A large panel of providers, primarily physicians, under contract with the Review Organization, is available for the California IMR system. The Review Organization attempts to have professionals in all recognized specialties and sub-specialties readily available to provide timely determinations. The Review Organization selects reviewers for a specific IMR based upon information obtained from the Department, the consumer, and the health plan.

Due to the unusual complexity, three physicians review investigational and experimental cases; medical necessity cases are normally reviewed by a single reviewer. Additional reviewers may be assigned to medical necessity reviews in complex cases or when the issues presented may not be adequately reflected in one reviewer's experience or expertise.

Each reviewer is asked prior to (and again upon completion of the review) whether they are knowledgeable of the treatment at issue; whether they have treated patients with the condition at issue; and whether they are credentialed or have privileges from a licensed health care facility in the diagnosis and treatment of the medical condition at issue. In general, cases are sent to either the same specialty as the patient's treating provider or the specialty that the patient has requested that the plan provide.

Within specific timeframes, the Review Organization is required to obtain written determinations by impartial medical experts, based on specific medical and scientific criteria. The decision of the Review Organization is sent to the Department, the patient, the treating physician, and the health plan.

Criteria Used by the Reviewers in Experimental/Investigational Cases

Determinations made by reviewers in medical necessity cases are required to state whether the disputed health care service is medically necessary and should be based upon:

- The specific medical needs of the patient, and

Any of the following:

- Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
- Nationally recognized professional standards;
- Expert opinion;
- Generally accepted standards of medical practice; or
- Treatments that are likely to provide a benefit to the patient for conditions for which other treatments are not clinically efficacious.

Criteria Used by the Reviewers in Medical Necessity Cases

The medical experts consider patients' medical records, health plan denial and grievance letters, supporting documentation from the patient and treating physician(s), and other appropriate documents submitted for review.

Determinations are based upon the specific medical needs of the enrollee and any of the following:

- Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
- National recognized professional standards;
- Expert opinion;
- Generally accepted standards of medical practice; or
- Treatments that are more likely to provide a benefit to the patient for conditions for which other treatments are not clinically efficacious.

Withdrawn IMRs

A withdrawal of an IMR can happen in three different ways:

♦ A health plan may reverse its original denial at any time during the independent medical review process up until the Review Organization renders its decision.

♦ A consumer may withdraw a request for an independent medical review at any time during the process.

♦ The Department may withdraw an application if it determines – during the review process – that the application is not eligible.

A majority of withdrawals are initiated by the health plan. Early in the IMR application process, the Department contacts the health plan to provide notification that the consumer's application is eligible for review. In some cases, the dispute is resolved through the Department's early intervention, and an independent medical review is no longer necessary.

WITHDRAWN IMRS – DATA

PARTY INITIATING THE WITHDRAWAL	NUMBER OF WITHDRAWALS	PERCENTAGE
Health Plan	95	84%
Patient	3	3%
Department of Managed Health Care	15	13%
TOTAL VOLUME	**113**	**100%**

Please note: Withdrawals occurred both prior to submission to the review organization (62 cases) and after submission to the review organization (51 cases).

Adoption of the Review Organization Determination

The Director of the Department formally adopts the recommendation of the IMR contractor as his decision. If the health plan's decision is overturned, the health plan is required to implement the findings within five days.

IMR Resolution Data: Uphold versus Overturn Rates

This chart provides information on the total volume of IMRs and identifies whether or not the health plan's original denial was upheld or overturned. Results are provided separately for Experimental / Investigational reviews and Medical Necessity reviews.

- **Upheld –** The health plan's original denial was upheld by the Review Organization.
- **Overturned –** The health plan's original denial was overturned by the Review Organization. The health plan is now required to provide the service to the consumer.

IMR RESOLUTIONS: UPHOLD VERSUS OVERTURN RATES – DATA

IMR TYPE	UPHELD		OVERTURNED		TOTAL
Experimental / Investigational IMR	126	82%	27	18%	**153**
Medical Necessity IMR	256	56%	201	44%	**457**
TOTAL RESOLUTIONS	**382**	**63%**	**228**	**37%**	**610**
TOTAL IMRS WITHDRAWN					**113**
TOTAL ELIGIBLE IMRS					**723**

** This data also includes cases that were opened in 2001, but closed in 2002.*

Publication of IMR Results & Other Information on the Website

Once a decision has been adopted, the statute requires the Department to make the contents of the decision available to the public. The names and identities of the consumer, physician, facility and health plan are not made public. In addition, the Department includes a synopsis of each completed review's diagnosis, the disputed treatment and whether the grievance was upheld or overturned. This information, provided in a user-friendly, searchable format, has been available on the Department's website since January 2002 and is believed to be unique to California as a valuable resource to consumers, providers, purchasers and health plans.

The Department's website also plays a key role in the distribution of general information about the IMR process. A "Frequently Asked Questions" page provides basic facts about the types of cases that are eligible for review and what an IMR can accomplish for a consumer.

Finally, visitors to the website can also obtain copies of the following IMR forms that the Department developed to assist consumers, providers, and health plans in presenting and responding to IMR cases.

♦ **IMR Application Form** gathers the basic information regarding the patient, health plan and the dispute, including the patient's authorization for the health plan to provide the relevant medical records. Health plans are required by statute to include an application (and an envelope addressed to the HMO Help Center) when a grievance decision denies, modifies or delays a requested health care service.

♦ **Request for Extension** is required if the IMR application was not presented within six months of the denied service or the health plan's grievance decision, whichever is later. The statute allows the Department to extend that deadline if the circumstances of the case warrant.

♦ **Physician Certification** is required if the IMR application concerns services denied by the health plan as experimental or investigational. A physician is required to establish that the consumer's medical condition is life-threatening or seriously debilitating and that a physician has

recommended a drug, device or service as more beneficial than available standard therapies. If the consumer's treating physician is not under contract with the health plan, the request for an IMR must reference or provide two medical or scientific documents to support the benefit of the requested services.

♦ **Declaration of Relationship Form** is required if the patient is incompetent or incapacitated, or requests representation. This form establishes the authority of a parent, guardian, conservator, relative, physician, attorney or other designee of the consumer to submit an application for IMR on behalf of the patient and to authorize the release of the patient's medical records.

♦ **Request for Health Plan Information** is used by the Department's HMO Help Center when necessary to obtain additional information to determine the eligibility of an IMR application.

♦ **IMR Health Plan Case Submission Form** is a suggested cover sheet for the information that the health plan must provide to the review organization when the health plan is notified by the Department that the application has been referred for an IMR.

Independent Medical Review Contracts and Costs of Reviews

On September 15, 2000, the Department published a "Request for Proposal" from potential review organizations for the new IMR system.

The Department contracts with three Review Organizations in order to ensure the ability to conduct reviews if the primary contractor is disqualified or unavailable due to conflicts of interest or to an inability to meet time requirements for reviews.

The primary contractor is The Center for Health Dispute Resolution (CHDR), a subsidiary of MAXIMUS, Inc. The two additional contractors are Medical Care Management Corporation and Hayes Plus, Inc.

Payment to the Review Organization is based on the type of case, the number of reviewers, and whether determinations must be expedited. The case fees for reviews performed by the primary contractor are:

REVIEW TYPE	COST
MEDICAL NECESSITY ONE PHYSICIAN	Standard: $ 395 Expedited: $ 500
EXPERIMENTAL/INVESTIGATIONAL THREE PHYSICIANS	Standard: $1,750 Expedited: $2,500

The Department pays the Review Organization on a monthly basis for the reviews completed during the preceding month. However, the costs for the IMR system are required to be borne by the health plans based on an assessment fee system established by the Department. Assessments are then levied monthly on the health plans to reimburse the Department for the cost of the reviews.

Independent Medical Review Quality Assurance System

Due to the unique and significant responsibilities delegated to the review organization, the Department has incorporated several systems to evaluate the overall performance of the reviewers and the IMR program in general.

Internal quality assurance systems function at each level of the IMR process. Before a case is labeled as "ineligible" for IMR, a supervisor must review the case. Cases requiring any interpretation of statute to determine eligibility are referred to counsel. Prior to the IMR determination being adopted by the Department, counsel evaluate the entire file to assure that the determination addresses all aspects of the dispute between the consumer and the health plan. Finally, on a bi-weekly basis, the IMR program manager conducts random audits of completed cases to determine whether all statutory and internal time processing requirements were met.

The Department's IMR Advisory Council is comprised of legal counsel, representatives of management, and the Director's medical advisor and has provided continuity in issue analysis and problem solving even before the program became effective. The Advisory Council meets monthly to assess any issues and problems that have been identified by HMO Help Center staff, health plans, consumers, or the Clinical Advisory Panel.

The Department's Medical Advisor monitors quality indicators, identifies trends, tracks concerns, and provides feedback to the Review Organizations. The Medical Advisor is also responsible for providing a quarterly summary of quality assurance results to the independent oversight committee, the Clinical Advisory Panel.

The Review Organizations under contract with the Department must have a quality assurance mechanism in place that ensures:

- Reviewers are appropriately credentialed and privileged;
- Reviews provided by the medical professionals are timely, clear and credible;
- Reviews are monitored for quality on an on-going basis;
- Reviewers are selected to achieve a fair and impartial qualified panel;
- The confidentiality of medical records and the review materials are maintained; and
- Reviewers are independent from any conflicts of interest.

In addition, certain minimal requirements are inherent in the state-contractor relationship. The Department's oversight includes (1) routine analyses to provide assurance that the contractors are meeting the requirements under the state agreement; (2) maximizing opportunities for informal presentation and resolution of problems; (3) timely identification, assessment and remediation on case-specific issues; and (4) periodic evaluations to assemble data and to identify needed systemic improvements.

The Clinical Advisory Panel (CAP) provides the Department with direct access to academic medical specialists who can provide expert assistance to the Director to ensure that the IMR system is "meeting the quality standards necessary to protect the public's interest." The CAP reviews

the decisions made during the independent review process to ensure that the decisions are consistent with best practices and to make recommendations where necessary. The CAP also reviews the adequacy and content of the reviews themselves, as well as the performance and quality assurance systems of the primary contractor.

In addition to the assessment of the trends demonstrated by the IMR decisions, the CAP has participated in reviewing the overall processes utilized by the Department. The CAP has provided recommendations and suggestions concerning:

♦ **Eligibility considerations and how applications and reviews are processed by the HMO Help Center.** Some of the recommendations in this area related to: determining whether cases should be expedited, reviewing limitations on retrospective reviews, and handling requests for re-reviews.

♦ **Assignment and qualifications of reviewers.** Some of the recommendations in this area related to: identifying and selecting qualified reviewers, ensuring appropriate experience and practice history of reviewers, and providing multiple reviewers in complex medical necessity reviews.

♦ **Content and adequacy of reviews.** Some of the recommendations in this area related to: the specificity and discussion of referenced medical evidence in the reviews and the medical literature search processes and system used by the reviewers.

♦ **Quality assurance systems.** Some of the recommendations in this area related to: consideration of audits for general consistency in results among reviewers, consideration of case scenarios to evaluate inter-relator reliability, and consideration of an independent audit of review organizations.

♦ **Public availability of IMR results.** Some of the recommendations in this area related to: obtaining consent of patients before results of reviews are made public, reviewing categorization of cases, and providing appropriate notice on the Department's website that past cases are not considered as precedent by either patients or health plans.

♦ **Evaluation of overall results of the California system.** Some of the recommendations in this area related to: comparing California results with overturn rates from other states, enhancing consumer education and outreach, and developing a feedback tool for health plan medical directors.

Trending and Tracking IMR Results

Decisions in individual IMR cases apply only to the specific dispute submitted by the enrollee and that health plan. Reviewer decisions are based on the specific medical history and needs of the requesting patient and do not constitute an overall assessment of any plan's medical policies applied in a particular case. However, the Department does evaluate the cases overall to determine if there are any trends in the types of disputes or in the results of IMRs to determine if there is a need for review of medical policies or treatments on a plan-to-plan basis or among the industry as a whole.

Working in conjunction with the CAP, the Department has an interagency agreement with University of California, San Francisco Institute of Health Policy Studies. This agreement provides available expertise to provide in-depth screening and evaluation of reviews for presentation to the Clinical Advisory Panel, as well as the opportunity for more focused studies on specific clinical areas of concern raised by the IMR system. Although various categories of cases are continuously under review, the results from the IMRs received in 2001 have been grouped to demonstrate the types of medical conditions and treatments that have gone through the review process.

Medicare and Medi-Cal Managed Care

Unlike some state IMR programs, enrollees in Medicare and Medi-Cal managed care plans licensed by the Department were specifically included. Although most other states exclude enrollees of Medicare and/or Medi-Cal managed care initiatives, the California statute encouraged an integration of its IMR system with the existing grievance and appeals processes under the federal Medicare and state Medi-Cal (Medicaid) managed care programs. The statute allowed the Department to "integrate the quality of care and consumer protection provisions, including remedies, of the Independent Medical Review System with related dispute resolution procedures of other health care agency programs, including the Medicare and Medi-Cal programs, in a way that minimizes the potential for duplication, conflict and added costs."

However, before the implementation date of California's new IMR process, the U.S. Department of Health and Human Services revised the regulations concerning the relationship of state laws and appeal and grievance processes under the Medicare + Choice program. In accordance with federal law, the California regulations specifically preempted Medicare + Choice plans from state processes that relate to the determination of benefits. A lawsuit was filed in federal district court by the California Association of Health Plans (CAHP) against the California Department of Managed Health Care to determine the extent of the Department's statutory and regulatory authority over Medicare + Choice plans. On August 27, 2001, the district court concluded that federal law specifically preempted the new IMR provisions. As a result, the Department was enjoined from enforcing the sections regarding Medicare + Choice plans.

Independent Medical Review Program Outreach Efforts

In order for the IMR program to achieve its intended purpose it is essential that managed care consumers and their health care providers are aware of the IMR program and how to access it. The IMR Outreach program focuses on activities that promote awareness that are in addition to notifications provided by health plans. The goal of the IMR Outreach project is simple: to publicize the availability of Independent Medical Review in California.

IMR Outreach activities focus on a variety of audiences and are conducted in at least three phases.

This phased approach initially focuses on outreach to the provider community through medical groups, physician and medical associations and specialty cancer treatment centers. The second phase focuses outreach to the employer community (human resource organizations, unions, brokers, benefit consulting firms, etc.), consumer groups (medical condition groups, health care support groups, etc.), and any medical and physician associations that were not contacted in the prior phase. The final phase focuses outreach efforts on rehabilitation providers (speech, occupational, and physical therapy providers), mental health and chemical dependency treatment providers, and additional consumer groups not contacted in the second phase.

Outreach efforts to the above-mentioned organizations are accomplished by:

- Providing newsletter articles for printing or electronic distribution
- Delivering on-site presentations
- Providing brochures and posters
- Offering links to the Department web-site
- Working with health plans to incorporate IMR information on their home pages

In addition, the Department is investigating use of media, including radio and television.

Independent Medical Review Critical Timelines

Statutory requirements, combined with Department policy, have produced a set of timelines for processing IMR cases. This chart outlines these critical timelines.

TRIGGERING EVENT	CASE TYPE		
	EXPEDITED MEDICAL NECESSITY	EXPEDITED EXPERIMENTAL OR INVESTIGATIONAL	STANDARD
	TIMELINES		
Department notifies consumer, consumer's physician and the health plan if the application is eligible.	Within **48 hours** of application receipt	Within **48 hours** of application receipt	Within **7 days** of application receipt
Health plan provides medical records/information to the Review Organization.	Within **24 hours** of Department notification	Within **24 hours** of Department notification	Within **3 days** of Department notification
Health plan provides new records (not available at the time of the original submission) to the Review Organization.	Within **1 day** of receipt	Within **1 day** of receipt	Within **1 day** of receipt
Review Organization renders determination.	Within **3 days** of receipt of records	Within **7 days** of receipt of records	Within **21 days** of receipt of records
Department adopts Review Organization determination and issues written decision.	Within **1 day** of receipt of Review Organization determination	Within **1 day** of receipt of Review Organization determination	Within **3 days** of receipt of Review Organization determination

TYPES OF IMRS

Experimental/Investigational Independent Medical Reviews

A patient can apply for an experimental/investigational IMR when he or she meets all the following conditions:

♦ The patient has a life-threatening or seriously-debilitating disease or medical condition;

♦ A request for services was denied by the plan or medical group based upon a finding that the drug, procedure, device or treatment is experimental or investigational; and

♦ A treating or supporting physician provides a certification that:

– The patient has a terminal medical condition, or a life-threatening condition, or a seriously debilitating condition;

– The standard therapies have not been effective in improving the patient's condition or the standard therapies would not be medically appropriate for the patient; or there is no more beneficial standard therapy covered by the health plan than the therapy proposed; and

– A statement that the requested therapy is likely to be more beneficial than any available standard therapy.

– If a non-plan physician is requesting the treatment, the statement must include copies or reference two documents from the medical and scientific evidence that the treatment is likely to be more beneficial for the patient that any available standard therapy.

EXPERIMENTAL / INVESTIGATIONAL REVIEWS: DIAGNOSIS – DATA

This chart identifies the top four categories of diagnosis (or medical condition) for experimental or investigational IMRs completed in 2001.

DIAGNOSIS	NUMBER OF CASES	IMR DETERMINATIONS		
		UPHELD	OVERTURNED	REVERSED
Musculoskeletal System Including back pain, arthritis, anklosing spondylitis, and injury	52	46	6	0
Cancer Including lung, esophageal, gastric, breast, colon, pancreas, renal rhabdomyosarcoma, prostate, melanoma, skin, and others	49	34	13	2
Uterine Fibroids	13	12	0	1
Neurological Including multiple sclerosis and migraine headaches	12	11	1	0
Total	**126**	**103**	**20**	**3**

Analysis and trend identification prepared by Dr. Wade Aubry, MD, University of California, San Francisco.

EXPERIMENTAL/INVESTIGATIONAL REVIEWS: DISPUTED TREATMENT – DATA

This chart identifies the top ten disputed treatments for experimental or investigational IMRs completed in 2001.

DISPUTED TREATMENT	NUMBER OF CASES	IMR DETERMINATIONS		
		UPHELD	OVERTURNED	REVERSED
Prescription Drug Therapy	55	35	20	0
Intra-Discal Electrothermal Treatment (IDET)	26	26	0	0
Uterine Embolization	15	13	1	1
Durable Medical Equipment (DME)	6	5	1	0
TOTAL	**102**	**79**	**22**	**1**

Medical Necessity Independent Medical Reviews

A patient can apply for a medical necessity IMR when he or she meets one of the following conditions:

♦ The patient's provider has recommended a health care service as medically necessary, or

♦ The patient has received urgent care or emergency services that a provider determined was medically necessary, or

♦ The patient, in the absence of a provider recommendation or the receipt of urgent care or emergency services by a provider, has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent medical review, or

♦ The patient has filed a grievance concerning the disputed care and the plan has either upheld its initial decision or has not taken action on the grievance within 30 days.

MEDICAL NECESSITY REVIEWS: DIAGNOSIS – DATA

This chart identifies the most frequent diagnoses (or medical conditions) for medical necessity IMRs completed in 2001.

DIAGNOSIS	NUMBER OF CASES	IMR DETERMINATIONS		
		UPHELD	OVERTURNED	REVERSED
Morbid Obesity / Obesity	40	9	29	2
Back Pain	32	17	12	3
Cancer	30	17	11	2
Arthritis / Osteoarthritis	14	10	3	1
Autism	13	9	4	0
Toenail Fungus	11	9	1	1
Diabetes	10	3	4	3
Sleep Apnea	10	4	4	2
Erectile Dysfunction	10	3	7	0
Lyme Disease	8	8	0	0
Depression	7	4	1	2
Breast Disorders	6	2	3	1
Eyelid Droop	6	5	1	0
TOTAL	**197**	**100**	**80**	**17**

MEDICAL NECESSITY REVIEWS: DISPUTED TREATMENT – DATA

This chart identifies the top seven categories of disputed treatment for medical necessity IMRs completed in 2001.

DISPUTED TREATMENT	NUMBER OF CASES	IMR DETERMINATIONS		
		UPHELD	OVERTURNED	REVERSED
Prescription Drug Therapy	120	74	34	12
Cosmetic vs. Reconstructive Surgery	52	24	26	2
Other Surgical Procedures	46	23	18	5
Durable Medical Equipment (DME) Including prosthetics and orthotics	42	21	14	7
Specialist Referral	41	16	18	7
Imaging Studies	30	18	8	4
Gastric Bypass	28	5	22	1
TOTALS	**359**	**181**	**140**	**38**

Analysis and trend identification prepared by Dr. Wade M. Aubry, MD, University of California, San Francisco.

Medical Necessity vs. a Coverage Decision

To be eligible for medical necessity IMR, a patient's case must involve a "disputed health care service." A disputed health care service is:

♦ Any health care service that is eligible for coverage and payment under a health plan contract that has been denied, modified, or delayed by a decision of the plan or by one of its contracting providers due to a finding that the service is not medically necessary.

The statute does not provide a definition of "medically necessary services". Each plan's evidence of coverage defines the term; however, the Department does not consider itself bound by the plan's definition of the term.

Health plan coverage decisions are not subject to IMR. A "coverage decision" is defined as:

♦ The approval or denial of health care services by a plan, or by one of its contracting providers, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health plan contract.

If a plan, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed services are not a covered benefit under the contract that applies to the enrollee, the statement is required to clearly specify the provision in the contract that excludes that coverage.

Standard versus Expedited Reviews

Generally, IMR cases are processed (through completion) within 30 days of qualification of the application. However, in certain circumstances, an IMR can be processed on an expedited basis.

For a service that has been denied based upon the finding that it is **experimental or investigational**, the IMR can be expedited if the consumer's physician states that the therapy would be significantly less effective if not promptly initiated. In these cases, the IMR is processed (through completion) within nine days.

For a service that has been denied, delayed or modified based upon the finding that it is **not medically necessary**, the IMR can be expedited if there is an imminent and serious threat to the health of the consumer. In these cases, the IMR is processed (through completion) within seven days.

EXPEDITED VERSUS STANDARD REVIEWS – DATA

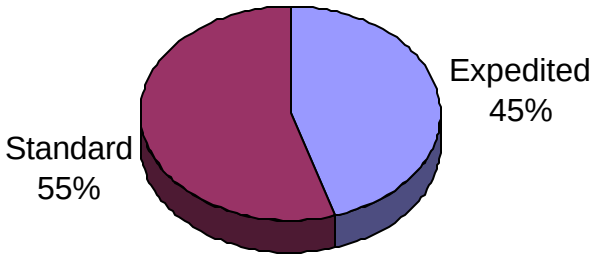
This chart provides information on the number of IMRs that were processed as expedited versus standard.

- **Standard IMR** – Resolved within 30 days of IMR application qualification.
- **Expedited Experimental/Investigational IMR** – Resolved within 9 days of IMR application qualification.
- **Expedited Medical Necessity IMR** – Resolved within 7 days of IMR application qualification.

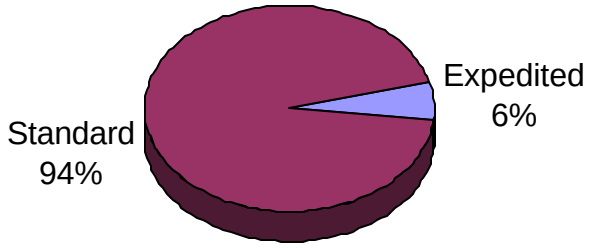
IMR TYPE	EXPEDITED	STANDARD	TOTAL
Experimental / Investigational IMR	70	85	**155**
Medical Necessity IMR	29	477	**506**
TOTAL EXPEDITED OR STANDARD CASES	**99**	**562**	**661**
TOTAL IMRS WITHDRAWN			**62**
TOTAL ELIGIBLE IMRS			**723**

This data also includes cases that were opened in 2001, but closed in 2002.

EXPERIMENTAL / INVESTIGATIONAL
Expedited vs. Standard Cases



MEDICAL NECESSITY
Expedited vs. Standard Cases



ISSUES & CHALLENGES - IMR

Enforcement Actions

In general, managed care plans have fully cooperated with the implementation of the Department's IMR system and throughout its first year of operation. Most plans had prior experience with one form or another of external reviews, either through the prior Friedman-Knowles Act or as part of their own grievance and appeal systems. Larger plans readily included a response to the Department's "Request for Health Plan Information" into their grievance and appeals process.

However, regulations do provide the Department with the authority to take enforcement actions against plans whose actions or inactions frustrate or impede the IMR system. A penalty of $5,000 per day is to be assessed when a health plan fails to implement an IMR decision within five days of its adoption by the Department.

The Department is reviewing several allegations related to health plans' non-compliance with the notification requirements of the IMR system. Despite clear statutory requirements, several plans have failed to include information about IMR in their denial letters and grievance resolution letters. To date, four penalties have been assessed and paid by health plans for the following reasons: 1) failure to provide records to the review organization within required timeframes; 2) failure to provide proper notice about filing a grievance and access to IMR; and 3) inaccurate notice of when the enrollee could contact the Department and failure to notify of IMR.

Litigation Actions

Even before the IMR system became effective, the California Association of Health Plans successfully argued in federal court that the California IMR system had been preempted from issuing determinations if the disputes arose from the Medicare managed care system ("Medicare + Choice").

In addition, a consumer group filed an action in late 2001 in Sacramento Superior Court, making broad assertions that the Department had failed to enforce several provisions of the Knox-Keene Act. In regards to IMR, the plaintiffs claimed that the Department had failed to provide enrollees with copies of the medical records that the health plan sends to the review organization. The case was dismissed with prejudice on March 12, 2002.

Utilization of IMR

Utilization of IMR was lower than anticipated during the first year. Based on information assembled by reports from the Kaiser Family Foundation and the American Association of Health Plans, states with IMR criteria similar to that of California average about .7 reviews per 10,000 enrollees. (The range is between .2 to 1.7 per 10,000.) Using the Department's first full year results – 723 eligible IMR cases - California's average is approximately .35 reviews per 10,000 enrollees.

The Department expected that the numbers of experimental and investigational reviews would be comparable to the prior IMR system in effect during 2000. The same types of cases are eligible – what changed is the application process for obtaining a review and the administration of the reviews. Yet the 153 reviews for experimental/investigational in the year 2001 is less than the total of 188 in the previous year. In addition, the significant difference in the overturn rate of about 20% for year 2001 compared to about 40% during year 2000 requires further analysis.

Provision of Materials for Review

Immediately following the January 1, 2001, implementation of the IMR program, most plans were able to appropriately respond and provide the necessary materials to the review organization upon notification by the Department that an IMR had been accepted for review. The few problems that arose occurred with the first cases going through the IMR process or with smaller plans and usually were resolved by telephone contacts between the Department, the plan and Center for Health Dispute Resolution (CHDR). Delays in the delivery of records occasionally still occur when the enrollee has been seen by out-of-plan providers or when the plan encounters difficulties in retrieving medical records from medical groups.

Notification of IMR Availability in Denial Letters

In addition to the allegations being reviewed by the Office of Enforcement, there are indications that some plans have failed to provide information about IMR when sending denial letters despite clear requirements defined by the statute. There are also indications of failure by some plans to appropriately monitor the content of letters sent by medical groups who have been delegated the authority to issue denials. In addition to addressing failure when it is discovered, the Department is working with the Industry Collaboration Effort (ICE) to develop templates for all denial letters with appropriate information about requesting IMRs.

Notification Provisions for Grievance and IMR Processes Differ

For several years, a verbatim statement has been required by statute that notifies a consumer of the Department's toll free telephone number and how grievances can be submitted to the Department for review. Referring to the plan's internal grievance process and the Department's review system, the statement provides notice that "your failure to use these processes does not preclude your use of any other remedy provided by law." However, the IMR application must provide notice that a decision not to participate in the IMR process may cause the consumer to forfeit the right to pursue legal action against the health plan. (Under California Civil Code §3428, if an enrollee does not apply for an IMR and attempts to obtain damages from the health plan for negligence, the cause of action may be dismissed.)

Medical Necessity vs. Coverage Issues

When there is a question whether an enrollee grievance is a disputed health care service or a coverage decision the Department makes the final determination. Since coverage under most health plans includes only medically necessary services, the distinction is, at times, somewhat blurred. In addition, some types of care involve areas where there exists no clear line between services that are typically considered medically necessary services and services that are excluded from coverage, such as medical vs. dental services, reconstructive vs. cosmetic surgery, and mental health vs. "educational/behavioral" therapy.

Some applications for IMR involve requests for care from a specific, out-of-plan provider (not contracted with the health plan) asserting that the out-of-plan physician is "better" than the in-plan physicians. These cases typically involve disputes concerning the selection or location of a **provider** rather than a disputed health care **service**. While the Department recognizes that reviewers should not be comparing providers' level of competency, the cases may present issues concerning the type of services available from the plan. The underlying basis for the consumer's request for a specific provider is reviewed to ensure that the dispute does not involve a medical condition that requires a medical specialty or a treatment alternative that is not available within the plan.

Copies of Documents Provided to the Review Organization

Plans are required to provide specified medical records and relevant documents to the review organization. The statute states "The plan shall promptly issue a notification to the enrollee, after submitting all of the required material to the Review Organization, that includes an annotated list of documents submitted and offer the enrollee the opportunity to request copies of those documents from the plan." Enrollees are notified that they may submit medical information or other relevant documentation to the review organization (they are not required to provide a copy to the plan). Any newly developed or newly discovered medical records are to be provided by the plan to the review organization immediately, with a copy to the enrollee. The Department is currently reviewing whether plans have provided appropriate information and copies of any materials not previously made available to enrollees. While there have been few cases in which "post-grievance" medical records and information have been submitted to the review organization, such submissions could be received too late for distribution to reviewers. The same is true when informing the plan of information provided by the enrollee in the course of the IMR process.

Retrospective IMRs for Reimbursement of Services Already Provided

With the exception of emergency and urgent services, disputes eligible for the Department's IMR system concern *recommended* or *proposed* care that the plan has denied, modified or delayed. Some plans and consumers have contended that the Department's reading of the statute is too narrow and other "retrospective" IMR cases should be allowed.

The language and tenses used throughout the statute confirm that review organizations will make determinations on prospective, not retrospective, services. In general, the IMR system was designed to resolve disputes over health care services prior to any harm to the enrollee caused by plan denials or delays of treatment. Therefore, the Department's authority is limited by the

terms of the Knox-Keene Act and its legislative history. Following an IMR determination, the Director's authority is limited to ordering a plan to provide reimbursement for emergency or urgent services.

Interestingly, under the IMR provisions in the Insurance Code, the Insurance Commissioner's authority to order reimbursement does not have a similar constraint. This disparity presents an issue related to the Department's jurisdiction over some Preferred Provider Organizations (PPO) products.

While none of the "ineligible" reimbursement applications for IMR are known to involve a PPO contract, the Department is assessing the apparent differences in the handling of applications arising from similar products between the Knox-Keene Act and the IMR provisions in the Insurance Code. Unlike managed care plans under the Department's jurisdiction, it is possible that some PPO contracts lack preauthorization and delegated authority provisions. Disputes may develop only after a contracting provider has provided services and there may be no pre-service findings on medical necessity and, therefore, no denial or opportunity to submit a grievance or IMR application until the plan's retrospective utilization management denial is received.

Applicability to Specialized Plans

Almost all of the reviews in 2001 arose from full-service plans. Section 1374.30(b) appears to require that the disputed health care service decisions eligible for IMR must relate to the practice of medicine. However, the following sentence states that disputes from specialized health care service plans are also subject to IMR if their services either involve the practice of medicine **or** are provided pursuant to a contract with a full-service plan. The latter provision could broaden the scope of IMR to services not commonly provided by physicians. In addition, the statute usually refers to "providers" or "medical professionals" rather than physicians. However, the dispute must rest on a determination of whether or not the service is medically necessary and there are references only to medical records and a medical condition. The Department has taken the position that disputes arising from specialized plans may be eligible for IMR only if the decisions involve matters normally within the scope of medical practice or are based on a physician recommendation.

Integrating Experimental/Investigational Reviews into the New IMR System

The previous Knox-Keene Act IMR provisions for experimental/investigational denials were amended and incorporated into the Department's IMR processes. There remain significant differences between these types of reviews. Experimental/ investigational reviews require additional supporting documentation to become eligible, are assessed under more rigorous scientific and medical criteria than medical necessity reviews, and the fees charged by the review organizations are considerably higher.

Some of the specific issues include:

- There is no process or unanimity among health plans that determines when a medical therapy is no longer "experimental." As a result, the type of IMR that similarly situated enrollees could receive is based on whether the plans choose to consider the treatment experimental or find it not medically necessary.

- The timeframes for completing experimental or investigational reviews are computed differently than medical necessity reviews. (Please refer to section "Independent Medical Review Critical Timelines.")

- Section 1370.4(a) states that each plan shall provide an external, independent review process but subsection (b) says that the plan's decision will be subject to the Department's IMR process.

- Under Section 1370.4(c)(1) plans are to notify enrollees of the opportunity to request IMR within five business days of the decision to deny coverage. But pursuant to Section 1367.01(h)(3) decisions to deny requests by providers for treatment authorization are to be communicated to the provider within 24 hours and to the enrollee within two business days.

- An IMR application is to be included in a plan's disposition of a grievance that denies, modifies or delays health care services as not medically necessary. However, experimental or investigational reviews may be initiated without utilizing the plan's internal grievance process. In addition there is no requirement that the enrollee receive an application, only notification of the opportunity to request an external independent review.

HMO HELP CENTER STATISTICAL DATA

HEALTH PLAN LICENSE INFORMATION

Health Plans Granted A License in 2001

A health plan may have no enrollees if the plan has recently been granted a Knox-Keene license. The Health Care Service Plans that received a license during 2001 are listed below.

HEALTH PLAN	DATE
Basic Chiropractic Health Plan	09/18/01
Concern: Employee Assistance Program	03/05/01

Licenses Surrendered by Health Plans in 2001

A health plan, which appeared in last year's report but does not appear in this year's, may have surrendered its Knox-Keene license. The Health Care Service Plans that surrendered their licenses during 2001 are listed below.

Health Plan	Date
Baycare Health Plan, Inc.	05/04/01
FPA Medical Management of California, Inc.	05/20/01
Kaiser Foundation Added Choice Health Plan	01/03/01
Primecare Dental Plan, Inc.	11/21/01
PriorityPlus of California	02/05/01
VivaHealth, Inc.	03/05/01

Health Plan Acquisitions in 2001

Health Plan	Acquired	Date
Jaimini Health Inc.	Primecare Dental Plan, Inc.	08/28/01
UnitedHealth Group, Inc.	Spectera Vision Services of California, Inc.	10/16/01

COMPLAINT RESULTS BY CATEGORY & HEALTH PLAN

Report Definition

The *Record of Consumer Complaints* details the number and types of complaints received by the Department during the 2001 calendar year.

The *Record of Consumer Complaints* lists health plans which were licensed during the 2001 calendar year, the number of complaints received against each health plan, the number of referrals to plan, the plan's average enrollment during the year, the number of complaints per 10,000 consumers, the number of accepted independent medical reviews (IMR), the number of health plan decisions upheld, the number of health plan decisions overturned, and the number of health plan decisions reversed.

Health Plans are listed according to their official licensed name. In instances where a plan is known by more than one name, the licensed name is shown first with additional names in parentheses.

Complaints are classified in six categories: Access to Care; Benefits/Coverage; Denial of Care/Payment; Quality of Care; Billing/Financial; and Attitude/Service.

Enrollment Information Definition

The health plan enrollment figures were provided to the Department by the health plans and reflect the average of the quarterly enrollment figures provided for 2001.

Report

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

California Department of Managed Health Care
Summary of 2001 Enrollee Complaints
01-01-2001 to 12-31-2001

Plan Type / Plan Name	Complaints Received	Referrals To Plan	Enrollees	Complaints Per 10,000 Enrollees	Issue Category: Accessibility Issues	Issue Category: Accessibility Issues Per 10,000 Enrollees
Full Service						
AETNA US Healthcare of California Inc.	162	43	862,537	1.8782	11	0.1275
Alameda Alliance for Health	1	0	75,955	0.1317	1	0.1317
Blue Cross of California	595	137	4,280,773	1.3899	37	0.0864
California Physicians' Service	392	114	1,350,547	2.9025	21	0.1555
Care 1st Health Plan	1	1	183,426	0.0545	0	0.0000
Cedars-Sinai Provider Plan LLC	0	0	910	0.0000	0	0.0000
Chinese Community Health Plan	0	0	7,659	0.0000	0	0.0000
Cigna Healthcare of California Inc.	175	32	661,163	2.6469	12	0.1815
Cohen Medical Corporation	7	0	141,652	0.4942	0	0.0000
Community Health Group	2	1	84,233	0.2374	1	0.1187
Concentrated Care Inc.	0	0	1,520	0.0000	0	0.0000
Contra Costa County Medical Services	1	0	55,589	0.1799	0	0.0000
Co. of Los Angeles Dept. of Health Services	2	1	131,794	0.1518	0	0.0000
County of Ventura	0	0	10,051	0.0000	0	0.0000
FPA Medical Management of California Inc.	0	0	0	0.0000	0	0.0000
Health Net of California Inc.	555	51	2,417,609	2.2957	29	0.1200
Health Plan of the Redwoods	24	2	75,117	3.1950	0	0.0000
Heritage Provider Network Inc.	0	1	168,878	0.0000	0	0.0000
Inland Empire Health Plan	2	0	211,832	0.0944	0	0.0000
Inter Valley Health Plan	24	1	67,571	3.5518	0	0.0000
Kaiser Foundation Added Choice	0	0	0	0.0000	0	0.0000
Kaiser Foundation Health Plan Inc.	817	135	6,218,145	1.3139	101	0.1624
Kern Health Systems Inc.	0	0	92,879	0.0000	0	0.0000
Lifeguard Inc.	28	4	236,228	1.1853	2	0.0847
Local Initiative Health Authority for LA County	0	0	712,582	0.0000	0	0.0000
Maxicare Health Plans Inc.	48	16	204,691	2.3450	9	0.4397
Molina Healthcare of California	3	0	237,026	0.1266	1	0.0422
National Med Inc.	12	2	35,277	3.4017	0	0.0000
On Lok Senior Health Services	0	0	878	0.0000	0	0.0000
One Health Plan of California Inc.	3	0	76,613	0.3916	1	0.1305
Orange Prevention and Treatment Integrated Medical Assistance	0	0	255,917	0.0000	0	0.0000
PacifiCare of California	659	91	2,161,642	3.0486	57	0.2637
Primecare Medical Network Inc.	1	0	242,458	0.0412	1	0.0412
Priority Plus of California	0	0	0	0.0000	0	0.0000
ProMed Health Care Administrators	0	0	14,806	0.0000	0	0.0000
Prudential Health Care Plan of California Inc.	95	28	304,862	3.1162	9	0.2952

California Department of Managed Health Care
Summary of 2001 Enrollee Complaints
01-01-2001 to 12-31-2001

Issue Categories									
Benefits/Coverage		Denial Care/Payment		Quality of Care		Billing/Financial		Attitude/Service	
Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees
42	0.4869	81	0.9391	15	0.1739	43	0.4985	5	0.0580
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
193	0.4509	233	0.5443	68	0.1588	174	0.4065	14	0.0327
124	0.9181	156	1.1551	27	0.1999	116	0.8589	14	0.1037
0	0.0000	1	0.0545	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
35	0.5294	107	1.6184	21	0.3176	21	0.3176	7	0.1059
1	0.0706	3	0.2118	0	0.0000	3	0.2118	0	0.0000
0	0.0000	0	0.0000	0	0.0000	1	0.1187	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	1	0.1799	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	2	0.1518	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
161	0.6659	279	1.1540	60	0.2482	96	0.3971	29	0.1200
6	0.7988	18	2.3963	2	0.2663	5	0.6656	2	0.2663
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	2	0.0944	1	0.0472	0	0.0000	2	0.0944
4	0.5920	8	1.1839	8	1.1839	5	0.7400	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
141	0.2268	260	0.4181	319	0.5130	112	0.1801	67	0.1077
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
6	0.2540	10	0.4233	3	0.1270	6	0.2540	3	0.1270
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
11	0.5374	24	1.1725	7	0.3420	11	0.5374	3	0.1466
0	0.0000	2	0.0844	1	0.0422	0	0.0000	0	0.0000
4	1.1339	6	1.7008	0	0.0000	3	0.8504	1	0.2835
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	2	0.2611	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
162	0.7494	328	1.5174	117	0.5413	92	0.4256	18	0.0833
1	0.0412	0	0.0000	0	0.0000	0	0.0000	1	0.0412
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
21	0.6888	51	1.6729	10	0.3280	22	0.7216	2	0.0656

California Department of Managed Health Care
Summary of 2001 Enrollee Complaints
01-01-2001 to 12-31-2001

Plan Type / Plan Name	Complaints Received	Referrals To Plan	Enrollees	Complaints Per 10,000 Enrollees	Issue Category: Accessibility Issues	Issue Category: Accessibility Issues Per 10,000 Enrollees
Full Service						
Regents of the University of California	2	0	12,078	1.6559	0	0.0000
San Francisco Health Plan	0	1	34,247	0.0000	0	0.0000
San Joaquin County Health Commission	0	0	56,505	0.0000	0	0.0000
Santa Barbara Regional Health Authority	0	0	50,359	0.0000	0	0.0000
Santa Clara County	1	0	49,274	0.2029	0	0.0000
Santa Clara County Health Authority	0	0	54,896	0.0000	0	0.0000
Santa Cruz-Monterey Managed Medical Care Commission	0	0	72,102	0.0000	0	0.0000
SCAN Health Plan	30	3	49,956	6.0053	5	1.0009
Scripps Clinic Health Plan Services Inc.	1	0	172,912	0.0578	0	0.0000
Sharp Health Plan	8	0	99,438	0.8045	1	0.1006
Sistemas Medicos Nacionales S.A.de C.V.	0	0	9,558	0.0000	0	0.0000
United Healthcare of California Inc.	12	2	0	0.0000	1	0.0000
Universal Care	25	1	328,914	0.7601	1	0.0304
Viva Health, Incorporated	0	0	0	0.0000	0	0.0000
WATTS Health Foundation Inc.	10	2	103,750	0.9639	0	0.0000
Western Health Advantage	4	0	51,772	0.7726	2	0.3863
Subtotals & Averages	3,702	669	22,728,577	1.6288	303	0.1333
Chiropractic						
American Specialty health Plans	0	0	4,227,156	0.0000	0	0.0000
Avante Complementry Health Plan	0	0	0	0.0000	0	0.0000
Basic Chiropractic Health Plan	0	0	0	0.0000	0	0.0000
ChiroSave Health Plan	0	0	847	0.0000	0	0.0000
Landmark Health Plan of California Inc.	0	1	313,900	0.0000	0	0.0000
Subtotals & Averages	0	1	4,541,903	0.0000	0	0.0000
Dental						
Access Dental Plan	1	0	120,099	0.0833	0	0.0000
AETNA US Healthcare Dental Plan of California Inc.	2	2	84,840	0.2357	1	0.1179
American Healthguard Corporation	0	0	17,973	0.0000	0	0.0000
Ameritas Managed Dental Plan Inc.	7	1	48,058	1.4566	0	0.0000
California Benefits Dental Plan	0	0	31,430	0.0000	0	0.0000
California Dental Network Inc.	0	1	17,502	0.0000	0	0.0000
Century Dental Plan	1	0	4,932	2.0275	0	0.0000
Cigna Dental Health of California Inc.	9	0	437,533	0.2057	0	0.0000
Community Dental services Inc.	6	1	65,297	0.9189	0	0.0000

California Department of Managed Health Care
Summary of 2001 Enrollee Complaints
01-01-2001 to 12-31-2001

Issue Categories

Benefits/Coverage		Denial Care/Payment		Quality of Care		Billing/Financial		Attitude/Service	
Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees
1	0.8279	1	0.8279	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	1	0.2029	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
6	1.2011	15	3.0027	10	2.0018	2	0.4004	0	0.0000
0	0.0000	0	0.0000	0	0.0000	1	0.0578	0	0.0000
1	0.1006	4	0.4023	0	0.0000	2	0.2011	1	0.1006
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
4	0.0000	7	0.0000	3	0.0000	2	0.0000	1	0.0000
6	0.1824	14	0.4256	2	0.0608	8	0.2432	1	0.0304
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
1	0.0964	8	0.7711	3	0.2892	0	0.0000	0	0.0000
2	0.3863	0	0.0000	0	0.0000	0	0.0000	0	0.0000
933	0.4105	1,622	0.7136	679	0.2987	725	0.3190	171	0.0752
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
1	0.0833	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	1	0.1179	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
3	0.6242	3	0.6242	2	0.4162	1	0.2081	1	0.2081
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
1	2.0275	0	0.0000	1	2.0275	0	0.0000	0	0.0000
2	0.0457	3	0.0686	2	0.0457	2	0.0457	0	0.0000
1	0.1531	1	0.1531	3	0.4594	1	0.1531	0	0.0000

California Department of Managed Health Care
Summary of 2001 Enrollee Complaints
01-01-2001 to 12-31-2001

Plan Type / Plan Name	Complaints Received	Referrals To Plan	Enrollees	Complaints Per 10,000 Enrollees	Issue Category: Accessibility Issues	Issues Per 10,000 Enrollees
Consumer Health Inc.	0	0	36,790	0.0000	0	0.0000
Dedicated Dental Systems Inc.	7	1	42,647	1.6414	0	0.0000
Delta Dental Plan of California	220	66	13,303,750	0.1654	2	0.0015
Dental Benefit Providers of California Inc.	1	0	185,749	0.0538	0	0.0000
Dental Health Services	4	0	86,011	0.4651	0	0.0000
DentiCare of California Inc.	15	0	427,302	0.3510	2	0.0468
Ideal Dental Health Plan Inc.	1	0	497	20.1207	1	20.1207
Jaimini Health Inc.	1	0	11,533	0.8671	1	0.8671
Managed Dental Care	0	0	53,212	0.0000	0	0.0000
Pacific Union Dental	7	1	260,422	0.2688	0	0.0000
PacifiCare Dental	14	1	507,789	0.2757	1	0.0197
Preferred Health Plan Inc.	0	0	8,485	0.0000	0	0.0000
Primecare Dental Plan Inc.	0	0	11,158	0.0000	0	0.0000
San Mateo Health Commission	0	0	38,709	0.0000	0	0.0000
UDC Dental California Inc.	1	0	21,590	0.4632	0	0.0000
United Concordia Dental Plans of CA Inc.	5	1	293,803	0.1702	0	0.0000
Western Dental Services Inc.	15	5	310,213	0.4835	1	0.0322
Subtotals & Averages	317	80	16,427,321	0.1930	9	0.0055
Dental/Vision						
Baycare Health Plan Inc.	1	0	0	0.0000	0	0.0000
Golden West Health Plan Inc.	2	0	264,142	0.0757	1	0.0379
Greater California Dental Plan	5	2	307,110	0.1628	0	0.0000
Private Medical-Care Inc.	31	12	1,259,232	0.2462	3	0.0238
Safeguard Health Plans Inc.	49	2	315,492	1.5531	3	0.0951
Subtotals & Averages	88	16	2,145,975	0.4101	7	0.0326
Pharmacy						
Merck-Medco Managed Care of California Inc.	0	0	63,017	0.0000	0	0.0000

California Department of Managed Health Care
Summary of 2001 Enrollee Complaints
01-01-2001 to 12-31-2001

Issue Categories									
Benefits/Coverage		Denial Care/Payment		Quality of Care		Billing/Financial		Attitude/Service	
Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
2	0.4690	2	0.4690	3	0.7034	2	0.4690	0	0.0000
82	0.0616	97	0.0729	30	0.0226	38	0.0286	6	0.0045
0	0.0000	0	0.0000	1	0.0538	0	0.0000	0	0.0000
0	0.0000	3	0.3488	3	0.3488	2	0.2325	0	0.0000
8	0.1872	4	0.0936	1	0.0234	3	0.0702	1	0.0234
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
2	0.0768	2	0.0768	0	0.0000	2	0.0768	2	0.0768
0	0.0000	3	0.0591	6	0.1182	2	0.0394	3	0.0591
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	1	0.4632	0	0.0000	0	0.0000	0	0.0000
4	0.1361	0	0.0000	2	0.0681	0	0.0000	1	0.0340
2	0.0645	2	0.0645	14	0.4513	1	0.0322	4	0.1289
108	0.0657	122	0.0743	68	0.0414	54	0.0329	18	0.0110
0	0.0000	0	0.0000	0	0.0000	1	0.0000	0	0.0000
0	0.0000	0	0.0000	1	0.0379	0	0.0000	0	0.0000
0	0.0000	1	0.0326	2	0.0651	3	0.0977	1	0.0326
7	0.0556	12	0.0953	16	0.1271	6	0.0476	3	0.0238
13	0.4121	24	0.7607	17	0.5388	5	0.1585	2	0.0634
20	0.0932	37	0.1724	36	0.1678	15	0.0699	6	0.0280
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000

California Department of Managed Health Care
Summary of 2001 Enrollee Complaints
01-01-2001 to 12-31-2001

Plan Type / Plan Name	Complaints Received	Referrals To Plan	Enrollees	Complaints Per 10,000 Enrollees	Issue Category: Accessibility Issues	Issue Category: Accessibility Issues Per 10,000 Enrollees
Psychological						
Avante Behavioral Health Plan	0	0	99,613	0.0000	0	0.0000
Cigna Behavioral Health of California Inc.	2	0	558,341	0.0358	0	0.0000
CONCERN: Employee Assistance Program	0	0	59,654	0.0000	0	0.0000
Health and Human Resource Center	1	0	186,440	0.0536	0	0.0000
Holman Professional Counseling Centers	0	0	200,023	0.0000	0	0.0000
Human Affairs International of California	0	0	1,355,365	0.0000	0	0.0000
Managed Health Network	5	0	2,382,683	0.0210	0	0.0000
Merit Behavioral Care of California Inc.	0	0	842,346	0.0000	0	0.0000
PacifiCare Behavioral Health of California Inc.	16	3	1,843,564	0.0868	0	0.0000
U.S. Behavioral Health Plan California	4	1	1,875,753	0.0213	0	0.0000
ValueOptions of California Inc.	0	0	255,433	0.0000	0	0.0000
Vista Behavioral Health Plans	0	0	97,724	0.0000	0	0.0000
Subtotals & Averages	28	4	9,756,937	0.0287	0	0.0000
Vision						
Eye Care Plan of America California Inc.	0	0	7,604	0.0000	0	0.0000
EYEMED Inc.	0	0	678,504	0.0000	0	0.0000
For Eyes Vision Plan	0	0	21,379	0.0000	0	0.0000
Foundation Health Vision Services	1	0	365,856	0.0273	0	0.0000
Medical Eye Services Inc.	1	0	70,454	0.1419	0	0.0000
NVAL Visioncare Systems of California Inc.	0	0	4,461	0.0000	0	0.0000
Pearle Visioncare Inc.	0	0	137,067	0.0000	0	0.0000
Procare Eye Exam Inc.	0	0	26,311	0.0000	0	0.0000
Spectera Vision Services of California Inc.	0	0	71,813	0.0000	0	0.0000
Vision First Eye Care Inc.	0	0	2,170	0.0000	0	0.0000
Vision Plan of America	0	0	38,152	0.0000	0	0.0000
Vision Service Plan	7	0	8,500,024	0.0082	0	0.0000
VisionCare of California	0	0	65,583	0.0000	0	0.0000
Subtotals & Averages	9	0	9,989,378	0.0090	0	0.0000
Totals & Averages	**4,144**	**770**	**65,653,107**	**0.6312**	**319**	**0.0486**

California Department of Managed Health Care
Summary of 2001 Enrollee Complaints
01-01-2001 to 12-31-2001

Issue Categories									
Benefits/Coverage		Denial Care/Payment		Quality of Care		Billing/Financial		Attitude/Service	
Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees	Issues	Issues Per 10,000 Enrollees
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	2	0.0358	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	1	0.0536
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
4	0.0168	3	0.0126	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
4	0.0217	13	0.0705	0	0.0000	0	0.0000	0	0.0000
1	0.0053	3	0.0160	0	0.0000	1	0.0053	0	0.0000
0	0.0000	0	0.0000	0	0.0000	1	0.0391	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
9	0.0092	19	0.0195	0	0.0000	4	0.0041	1	0.0010
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	1	0.0273	0	0.0000	0	0.0000	0	0.0000
1	0.1419	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
3	0.0035	3	0.0035	0	0.0000	2	0.0024	0	0.0000
0	0.0000	0	0.0000	0	0.0000	0	0.0000	0	0.0000
4	0.0040	4	0.0040	0	0.0000	2	0.0020	0	0.0000
1,074	**0.1636**	**1,804**	**0.2748**	**783**	**0.1193**	**800**	**0.1219**	**196**	**0.0299**

INDEPENDENT MEDICAL REVIEW RESULTS BY HEALTH PLAN

Report Definition

This report details the number and types of IMRs received by the Department during the 2001 calendar year.

The report lists health plans which were licensed during the 2001 calendar year, the number of IMRs received by health plan, the associated uphold and overturn determinations, and the number of IMR withdrawals. Enrollment data is provided for comparison purposes.

Total cases reported on this chart (661) vary from the total cases eligible (723) due to withdrawn IMRs (62). This chart lists only those IMRs for which a determination was rendered.

Enrollment Information Definition

The health plan enrollment figures were provided to the Department by the health plans and reflect the average of quarterly enrollment provided for 2001. Because Medicare + Choice enrollees are not eligible for IMR, the enrollment figures below exclude them. (The average quarterly HMO enrollment for Medicare + Choice was 1,437,139.)

Total Enrollment on this report excludes Managed Health Network as it is a specialized plan, not a full service plan.

California Department of Managed Health Care
Summary of IMRs by Health Plan
January 1, 2001 – December 31, 2001

Health Plan Name	Enrollees	Total IMRs	IMRs per 10,000 Enrollees	Experimental/Investigational IMR			
				Total IMRs	Plan Upheld	Plan Over-turned	IMR With-drawn
AETNA US Healthcare of California Inc.	817,824	18	0.22	5	5	0	0
Blue Cross of California	4,244,284	67	0.16	30	26	3	1
Blue Shield - California Physician's Service	1,257,793	147	1.17	46	36	9	1
Cigna Healthcare of California	661,163	49	0.74	5	4	0	1
Community Health Group	84,233	3	0.36	0	0	0	0
Health Net of California Inc.	2,275,985	156	0.69	25	24	1	0
Health Plan of the Redwoods	63,933	13	2.03	3	1	2	0
Kaiser Foundation Health Plan	5,597,761	37	0.07	3	2	1	0
Lifeguard Inc.	236,228	5	0.21	2	1	1	0
Managed Health Network	2,382,683	4	0.02	0	0	0	0
Maxicare Health Plans Inc.	198,620	2	0.10	0	0	0	0
Pacificare of California	1,646,501	151	0.92	35	25	10	0
San Joaquin County Health Commission	56,505	1	0.18	0	0	0	0
Sharp Health Plan	99,438	1	0.10	0	0	0	0
Universal Care	328,914	3	0.09	0	0	0	0
Western Health Advantage	49,269	4	0.81	2	2	0	0
Total	**17,618,451**	**661**	**0.38**	**156**	**126**	**27**	**3**

California Department of Managed Health Care
Summary of IMRs by Health Plan
January 1, 2001 – December 31, 2001

Health Plan	Medical Necessity IMR			
	Total IMRs	Plan Upheld	Plan Over-turned	IMR With-drawn
AETNA US Healthcare of California Inc.	13	7	2	4
Blue Cross of California	37	24	11	2
Blue Shield - California Physician's Service	101	55	30	16
Cigna Healthcare of California	44	20	22	2
Community Health Group	3	0	3	0
Health Net of California Inc.	131	65	62	4
Health Plan of the Redwoods	10	3	4	3
Kaiser Foundation Health Plan	34	17	13	4
Lifeguard Inc.	3	0	3	0
Managed Health Network	4	2	0	2
Maxicare Health Plans Inc.	2	1	1	0
Pacificare of California	116	61	45	10
San Joaquin County Health Commission	1	0	1	0
Sharp Health Plan	1	0	1	0
Universal Care	3	0	2	1
Western Health Advantage	2	1	1	0
	505	**256**	**201**	**48**